University of Alberta

Making a Difference in Critical Care Nursing Practice: An Interpretive Inquiry

by

Mary Patricia Hawley ©

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To nurse—really, truly—is art, and our art holds the power we need to unite us, keep us going, move us forward. It's time, high time, to unleash it. (Masson, 1991, p. 187)

Dedication

To critical care nurses—the ones in the trenches, on the front lines

Abstract

This interpretive inquiry reveals the meaning in critical care nurses' lived experiences of "making a difference" in critical care nursing practice with a view to deepening an understanding of the art of nursing and pursuing nursing excellence. In particular, it "shows" how critical care nurses make a difference and what difference they make to patients who experience critical illness in a manner that more fully captures the reality, complexity, diversity, and subtlety embodied in artful nursing practice as it is enacted in the critical care setting. Sixteen critical care nurses participated in conversations about memorable experiences in which they believed that they made a difference in their practice. The transcripts were subjected to a thematic analysis and reflective process from which the investigator identified the following themes as descriptive of the meaning of the experience of making a difference in critical care nursing practice: making the inhumane humane, making the unbearable bearable, making the life threatening life sustaining, and making the unliveable liveable. In turn, guided by the lifeworld existentials of spatiality, corporeality, temporality, and relationality, these themes became the threads around which an interpretive-descriptive reflective text was written. In keeping with the tradition of hermeneutic phenomenology, other relevant sources of lived-experience material, such as that found in literary sources and in the phenomenological works of others, were collected and woven into the evolving text to assist with the explication of meaning. Therefore, this inquiry contributes to the growing body of substantive knowledge related to the art of nursing as found in the everyday lived experiences of nurses.

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CHAPTER 1

INTRODUCTION

"I don't know of any profession where one can so deeply walk into another person's life and potentially make a difference. It's such a privilege" (Dossey; as cited in Bronson-Gray, 1995, p. 16). Dossey's words about the profession of nursing not only deeply resonate with me, a nurse of 28 years; but they also echo the sentiment of many nurses. However, although nurses are convinced that what they do makes a difference to patients, what does making a difference mean? What is the nature of making a difference in the context of nursing practice? How do nurses make a difference? What difference do nurses make? Let me share my story about making a difference in Bob's life (Hawley, 2000a):

> I had a patient, Bob, a high school teacher and soccer coach. He was 29 years old. He was admitted to our neurosurgical ICU with a broken neck. It was the last day of school. The teachers were having a party at the principal's cottage at the lake. Bob dived into shallow water.
>
> One day an independent, active man, whole and mobile. The next, he lies in a hospital bed, motionless. His head suspended in traction. Mouth, face, and eyes are the only body parts moving. Within hours of his admission his breathing became shallow and rapid, his breathing muscles getting progressively weaker. He required the support of a ventilator. No longer able to speak, blinking became his only means for communication—one blink for yes, two for no.
>
> One day I sensed that Bob was having a rough time—I just knew. I could feel the tension. He was experiencing a lot of pent-up frustration. Just before leaving I bent over and said, "Bob, when I go for coffee, . . . I'll scream for you."

> Later, when Bob was breathing on his own and able to talk again, he said, "I've been waiting all this time to tell you that I will never forget the day you said you would scream for me. I knew then that somebody really understood. It's what has given me the will to keep on living and fighting." (pp. 18-19)

As I ponder this nursing experience and others about making a difference, I believe that these experiences reflect the art of nursing. I see the art of nursing alive, being lived. Thus, I believe that a formal inquiry into nurses' lived experiences of making a difference is a way to reveal the meaning in these experiences and subsequently deepen the understanding of the art of nursing and, in turn, "unleash" the art of nursing.

Orientating to the Phenomenon

> Nursing is an art; and if it is to be made an art, it requires as exclusive devotion, as hard a preparation as any painter's or sculptor's work, for what is the having to do with dead canvas or cold marble, compared with having to do with the living body: the temple of God's spirit? It is one of the fine arts; I had almost said, the finest of the fine arts. (Florence Nightingale, 1859/1992)

Historical and contemporary views of nursing support the idea that nursing is an art and a science (Appleton, 1993; Carper, 1978/1997; Chinn, Maeve, & Bostick, 1997; Gaydos, 2004; Hampton, 1994; Johnson, 1991, 1993, 1994, 1996a, 1996b; LeVasseur, 1999, 2000, 2002; Parker, 1997; Peplau, 1988; Rodgers, 1991/1997; Rose & Parker, 1994). However, to date, the evolution of nursing scholarship has been primarily focused on developing nursing science, with only cursory attention paid to the subject of nursing art (Appleton, 1993, Chinn & Watson, 1994; Johnson, 1993, 1994; Katims, 1993; Parker, 1997; Ray, 1997). Although this focus on nursing science may have facilitated the establishment of professional and academic credibility for nursing, it has been at the expense of advancing scholarship in the realm of nursing art (Appleton, 1993; Chinn & Watson, 1994; Darbyshire, 1994; Johnson, 1993, 1994).

Although the concept of nursing art is at once familiar, it is yet mysterious and ill defined (Katims, 1993). Nursing has not yet articulated a clear picture of the nature of the art of nursing. According to LeVasseur (1999), "If one is to employ the word 'art' with accuracy, the nature of nursing art should be elucidated" (p. 49). In Smith's (1999) words, "Any professional discipline must seek to understand its art of practice. There is substantive knowledge related to nursing's art and this is a legitimate area of scholarship. It is essential to more fully understand the art of nursing" (p. 19). In reference to the art of nursing, Parker (1997) contended that "as all artists need to know something about their art, so do nurses need to know something about their nursing" (p. 13). Kim (1993) asserted that to achieve a fuller understanding about what nurses do in practice and to find ways to improve nursing practice, scholarly attention to the art of nursing is critical. As well, Benner (1984), Johnson (1993, 1994), and Katims suggested that if nursing is to pursue and achieve excellence in practice, nurses must deepen their understanding of the art of nursing. Similarly, Benner spoke to the "power of understanding for becoming more effectively, skillfully, and humanly engaged in nursing practice" (p. xv). LeVasseur (1999, 2000, 2002) and Bishop and Scudder (1991) also stressed the importance of understanding the art of nursing. As LeVasseur (1999) stated, "It is crucial that nurses understand how they affect patients and how they can facilitate and promote transitions from one state of health to another. To comprehend this fully, nurses need to understand the art of nursing" (p. 58).

How can a deeper understanding of the art of nursing be pursued and achieved? Knowledge about the art of nursing is embedded in practice (Appleton, 1993, 1994; Benner, 1984, 1994; Benner & Wrubel, 1989; Benner, Hooper-Kyriakidis, & Stannard, 1999; Benner, Tanner, & Chesla, 1996; Chinn et al., 1997; Cooper, 2001; Davies, 1993; Kim, 1993; Kolcaba, 1995b; Rose & Parker, 1994; Smith, 1992). Therefore, to seek an understanding of the art of nursing, one must study nursing practice. It is only by studying nursing practice that the complexity, situatedness, richness, and significance of the art of nursing can be fully captured and understood—a feat that can never be fully achieved by the development of abstract, formal models (Benner, 1984; Cameron, 1998; Morse, 1996a). However, given the view that the study of nursing art should be placed in the practice arena, nurse scholars—for example, Benner (1984)—have been quick to point out that description of procedural tasks or competencies alone will not capture the myriad of dimensions of artful nursing practice. According to Benner, artful nursing practice is relational and therefore cannot be adequately understood by using strategies that leave out content, context, and function. Similarly, Bishop and Scudder (1991) made the point that objective methods that categorize and quantify practices are insufficient for understanding the art of nursing.

For knowledge that distinguishes nursing as an art to emerge, direct inquiry into an experience that reveals the art of nursing must be involved (Appleton, 1994). When this experience is known in terms of how it is constituted and the meaning that it holds for the knower, then a deeper understanding of the nature of the art of nursing is achieved (Appleton, 1994). Thus, "the study of the nature of the art of nursing requires a philosophical perspective and methodological approach capable of explicating its complex nature within the context of a system of health care" (p. 92). Hermeneutic phenomenology, a philosophical methodology, is such an approach (Appleton, 1993, 1994; Benner, 1984; Benner et al., 1999; Benner et al., 1996; Bishop & Scudder, 1991; Leininger, 1985; Ray, 1991; Taylor, 1993). Hermeneutic phenomenology, which seeks to disclose meaning as encountered in the lived world, offers a way to explore the art of nursing as found in the everyday lived experience of nurses (Appleton, 1993, 1994; Bishop & Scudder, 1991).

In hermeneutic phenomenological inquiry, descriptions of lived experience are a credible source for explicating meaning. Therefore, what everyday lived experience of nurses might best capture the art of nursing? In recent years the phrase "making a difference" has become a cliché in nursing circles. The slogan "Nurses make the difference" was adopted by the Canadian Nurses Association (CNA) and used as the theme for their Biennial Convention in 1996. It was also adopted by the Alberta

Association of Registered Nurses (AARN) and used in their media campaign during Nurses Week in 1997 (D. Phillipchuk, personal communication, October 14, 1997). It has since appeared in themes for numerous nursing conferences in Canada, the United States, and Australia. Nurses often speak about making a difference in people's lives as playing a role in their choice of career, sustaining their professional commitment, or both. For them, making a difference is the living out, the enactment, of their professional role (Perry, 2002). Because the phenomenon of making a difference is one that nurses have experienced and can thus relate to, an exploration of the lived experience of making a difference in nursing practice has the potential to uncover knowledge about the nature of the art of nursing.

Given that my experience and continued professional interest lie in the area of adult critical care nursing, this inquiry focused on critical care nurses in adult settings. Therefore, in this inquiry I explored the lived experience of making a difference in critical care nursing practice. The research question guiding the inquiry was, What is the lived experience of making a difference in critical care nursing practice? The aim of this inquiry was to explicate the meaning of the lived experience of making a difference in critical care nursing practice and, subsequently, to seek a deeper understanding of the nature of the art of nursing. Critical care nursing is an essential part of the health care system. Within this complex and dynamic place of care, an understanding of how nursing care makes a difference to critically ill patients during this time of crisis is essential in promoting positive outcomes.

The Potential for This Inquiry to "Make a Difference"

> Only nurses can say—and say well—that which they know best (Styles & Moccia, 1993, p. 330). Nurses' voices are needed if the art of nursing is to be uncovered, understood, rewarded, celebrated, preserved, and promoted.

As Schlotfeldt (1988) stated, "There can be little doubt that one of the highest priorities for creating an appropriate future for nursing is that of identifying, structuring, and continuously advancing the knowledge that underlies the practices of professionals in the field" (p. 35). As indicated in the introductory statements of this dissertation, the development of substantive knowledge related to the art of nursing is not only a legitimate area of scholarship, but it is also essential scholarship in the pursuit and achievement of excellence in nursing practice. This inquiry, in seeking a deeper understanding of the nature of the art of nursing, contributes to the growing—albeit slowly—body of knowledge about "the art of nursing and the aesthetic pattern of knowing in nursing" (Chinn & Watson, 1994, p. xvi).

This inquiry may also expand self-awareness (Drew, 1997) and foster "aesthetic insight" (Moyle, Barnard, & Turner, 1995, p. 964) among practitioners of nursing. By engaging practitioners in a process of reflection on the meaning of the lived experience of making a difference, the potential for practitioners to grow and "acquire a measure of self-understanding" (Drew, 1997, p. 407) exists. In turn, this process may foster aesthetic thoughtfulness (Merkle-Sorrell, 1994) in their nursing practice. As Bishop and Scudder (1991) suggested, "Enlightenment of practitioners, rather than prescription of practice . . . makes it possible for nurses to innovatively give nursing care in a way that fosters the well-being of patients, nurses, and of the practice itself" (pp. 103-104). Perry (1994, 1998) proposed that reading about the artful practice of others could be a method of learning alternate practice approaches. Similarly, Van der Zalm and Bergum (2000) asserted that through inquiry of this nature,

> practicing nurses have the opportunity to find meaning in and understand everyday situations with patients, to discuss and communicate their understanding with others, and as a result, to change their actions or the actions of others in subsequent situations on the basis of that understanding. (p. 217)

By imparting understanding that yields "practically relevant" (Van der Zalm & Bergum, 2000, p. 213) knowledge, this inquiry may enable practitioners of nursing "to come to know new possibilities for nursing practice" (Boykin & Schoenhofer, 1993, p. xi) so that they are able to communicate with and act toward patients in a more thoughtful manner (Van der Zalm & Bergum, 2000). As van Manen (2002b) purported, understanding in the phenomenological sense has the potential to sponsor more "thoughtful action: action full of thought and thought full of action" (p. 88).

Although the development of knowledge as understanding took primacy in this scholarly endeavor, this inquiry also "celebrates and gives testimony to the art of nursing" (Chinn & Watson, 1994, p. xvii). Given a health care milieu in which the quest to "cure" predominates and science and technology reign supreme, the art of nursing often remains hidden or invisible (Benner, 1984; Bronson-Gray, 1995; Cooper, 1993; Duke & Copp, 1992; Morse, 1992; Roberts, 1990; Walters, 1995; Wolf, 1989). As a result, the significant work of nurses is undervalued (Benner & Wrubel, 1989; Duke & Copp, 1992; Montgomery, 1993; Roberts, 1990) and largely goes unrecognized (Benner, 1984), unacknowledged (Morse, 1992), and unrewarded (Benner, 1984). This problem has been compounded by the fact that, although nurses are convinced that what they do makes a difference, nursing has lacked evidence of what nurses do and what difference they make.

Although some of what nurses do is easily measured (e.g., pain reduction), much of what they do is not (Bronson-Gray, 1995). Accordingly, many of the actions and interactions that contribute to positive patient outcomes do not make it into the research literature (Wolf, 1989), do not appear on critical pathways (Bronson-Gray, 1995), are not factored into staff workload measurement for the purpose of determining appropriate patient assignments, and are not assigned monetary value (Ekegren, Nelson, Tsolinas, & Ferguson-Dietz, 1997). Thus, if nursing is to preserve its vital role in health care, receive the credit that it is due, and advance as a profession, the art of nursing must be made visible in all its aspects (Benner, 1984; Benner et al., 1996; Boykin & Schoenhofer, 1993; Cooper, 1993; Duke & Copp, 1992; LeVasseur, 2002; Morse, 1992; Styles & Moccia, 1993; Wolf, 1989). As Pearson (1993) suggested, this requires an "increasing research investment in exploring the lived experience of care in health and illness" (p. 165). By exploring the lived experience of making a difference in critical care nursing practice, this inquiry helps to uncover the hidden, but significant, work of nurses; and by echoing the voices of nurses, it provides valuable insight into how nurses make a difference and what difference nurses make. Shinn (1993) observed, "Nursing has a story to tell—a story about competent professionals who can and are making a difference daily in the health of the nation" (p. 8). The lived experience of making a difference in critical care nursing practice, as it has evolved in this inquiry, contributes to the composition of such a story. In so doing, it recognizes, acknowledges, celebrates, and pays tribute to the profession of nursing and holds the potential to "empower nurses personally and professionally" (Wolf, 1989, p. 466).

CHAPTER 2

THE ART OF NURSING: A REVIEW OF THE LITERATURE

> The real essence of nursing, as of any fine art, lies not in the mechanical details of execution, nor yet in the dexterity of the performer, but in the creative imagination, the sensitive spirit, and the intelligent understanding lying back of these techniques and skills. Without these, nursing may become a highly skilled trade, but it cannot be a profession or a fine art. (Stewart; as cited in Donahue, 1996, p. 500)

I conducted a review of the literature chiefly to provide a conceptual background for this inquiry by explicating what has been revealed about the nature of the art of nursing. In so doing, I also indirectly supported my position that nursing has yet to achieve a deep understanding of the nature of the art of nursing and that an interpretive inquiry into an experience that reveals the art of nursing such as the one herein can make a significant contribution toward achieving a deeper understanding of the nature of the art of nursing. This body of knowledge relevant to nursing art is revealed through the presentation and discussion of the link between nursing science and nursing art, definitions of nursing art, and the contributions made through other researchers' formal inquiry.

The Link Between Nursing Art and Nursing Science

Some nurse scholars believe that nursing art and nursing science are distinct entities, that the art of nursing represents all that cannot be accounted for by science. This belief is best exemplified by Katims' (1993) claim that "the art of nursing is considered that part of nursing that is not grounded in scientifically-derived or theoretical knowledge" (p. 269). For many nurse scholars, however, the idea that nursing art and nursing science are interconnected or integrated prompts little argument (Brink, 1993; Gendron, 1994; Johnson, 1991; LeVasseur, 1999; Peplau, 1988; Rose, 1997; Rose & Parker, 1994). Yet despite this more popular latter view, few nurse scholars have clearly articulated this link between nursing art and nursing science.

Comments such as "science and technology are the tools for the art of nursing" (Rose, 1997, p. 26) are vague and thus not very informative.

Johnson (1991) is one nurse scholar who can be credited with articulating a link between nursing science and nursing art. As a point of departure, Johnson broadly defined nursing science as empirical nursing knowledge derived from investigative efforts. This scientific knowledge is generated in the form of rules and principles and is generalizable in nature. Johnson referred to nursing art as "the ability to nurse well" (p. 10) and broadly defined it as "the practical know-how that an individual nurse has in a particular situation, which is used to achieve a particular result" (p. 10). One underlying assumption in Johnson's work regarding this link between nursing science and nursing art is that "nursing science must ultimately serve the art of nursing" (p. 9). Another underlying assumption is that this link is upheld only if nursing science is conceptualized and pursued as a practical science. A practical science is one in which the aim is to develop knowledge for the purpose of doing; or, in other words, achieving a practical end or goal (Wallace, 1983). As such, this conceptualization of nursing science is most appropriate for nursing. Given that nursing is a practice discipline (Dickoff & James, 1968/1997; Donaldson, 1995; Donaldson & Crowley, 1978/1997; Meleis, 1997; Wallace, 1983) with a practical aim, the development of knowledge that is prescriptive in nature (i.e., guides action) is essential (Dickoff & James, 1968/1997; Donaldson, 1995; Donaldson & Crowley, 1978/1997; Gortner, 1990, 1993/1997; Meleis, 1997; Schumacher & Gortner, 1992).

Johnson (1991) explicitly expressed the idea that nursing science must presuppose nursing art (p. 9). However, further examination of her work, which also includes Johnson (1996b), revealed that a more inclusive link is implied. This implied link between nursing science and nursing art can be formulated as being somewhat circular in nature; that is, nursing art presupposes nursing science, which presupposes nursing art. The first notion that is implied in this formulation is that to develop nursing as a practical science, some idea about what it means to nurse well (artfully) must exist to provide direction for this development. Therefore, from this perspective, to nurse well (artfully), nursing science must presuppose nursing art. In other words, the development of nursing science must be driven by some knowledge of nursing art. As Johnson (1996b) stated, "One cannot develop sound principles to guide action unless one first possesses knowledge about the end that is to be achieved and the factors that may influence the achievement of that end" (p. 39).

However, to nurse well (artfully), which implies the achievement of a particular end or goal, scientific knowledge should not be blindly or rigidly applied in the particular situation. Given the reality in which nursing is practiced, nurses must deal not only with unique individuals, but also with an imperfect environment that often presents contingent circumstances. Thus, rules and principles alone, no matter how explicit, will never be sufficient for artful nursing practice (Johnson, 1996b). Therefore, while artful nursing practice must be guided by scientific knowledge, nurses must "choose wisely and well" (p. 48) among these rules and principles in determining how to apply this scientific knowledge to achieve a particular end. Johnson contended that this is best achieved when knowledge of the particular situation, skill, and "artistic nursing prudence" (p. 48) complement the nurse's knowledge of scientific rules and principles. This second notion implies that to nurse well (artfully), nursing art must presuppose nursing science.

In summary, the explication of the link between nursing science and nursing art, as described above, supports the idea that the art of nursing is practical in nature, that it is concerned with achieving a particular end or goal. Furthermore, it reveals that the art of nursing embodies scientific knowledge, skill, understanding of the particular situation, and prudent judgment.

The Nature of the Art of Nursing

More than 100 years ago, Florence Nightingale, the founder of modern nursing, claimed that nursing was the finest art. Since that time nurse scholars have strongly agreed that the art of nursing exists. Although much has been said about the art of nursing over the years, very few nurse scholars have articulated an actual definition of the art of nursing in their work. Katims (1993) suggested that this might partly be due to the fact that because the art of nursing evokes such a common understanding among nurses, any urgency to define it has been curtailed. Furthermore, for those nurse scholars who have offered a definition of the art of nursing, there is little evidence of agreement among them (Chinn & Kramer, 1999; Johnson, 1993; Katims, 1993; LeVasseur, 1999, 2000). Johnson suggested that this disagreement may to some extent be the result of nurse scholars' tendency to work in isolation, which, as a result, has contributed to the general state of "disarray" (p. 9) that characterizes the literature relevant to the art of nursing.

As part of her landmark doctoral dissertation entitled "Toward a Clearer Understanding of the Art of Nursing," Johnson (1993) set out to identify points of topical agreement in the literature on the art of nursing. Based on the areas of topical agreement, she subsequently defined the art of nursing as "a developable ability that perfects a nurse's practice and is possessed only by a nurse" (p. 242). However, a great deal of discord exists at this time in nursing on the definition of nursing art. Wiedenbach (1964) defined it as "the systematic application of knowledge, judgement, and skill toward meeting a need-for-help experienced by the patient" (p. 36). According to Wiedenbach, "The art of nursing is goal directed, deliberatively carried out, and patient centered" (p. 23). She added that nursing art is "individualized action, carried out by the nurse in a one-to-one relationship with the patient and constitutes the nurses' conscious responses to specifics in the patient's immediate situation" (p. 36). Furthermore, she contended that "underlying this action is a thinking-feeling process in which the analysis of information is involved" (p. 36).

In earlier work, as mentioned, Johnson (1991) referred to nursing art as "the ability to nurse well" (p. 10) and defined nursing art as "the practical know-how that an individual nurse has in a particular situation, which is used to achieve a particular result" (p. 10). Bishop and Scudder (1991) also commented that nursing art is about the care of a particular patient in a given situation. According to these researchers, the art of nursing involves the integration of technical, personal, relational, and moral aspects of care. Similarly, LeVasseur (1999) asserted that, as each nurse-patient encounter is marked by a "never-the-same-again quality," part of the art of nursing is "knowing how to respond in these infinitely variable situations" (p. 60). For LeVasseur, an engaged, emotional commitment is a precondition for nursing art.

Katims (1993) considered nursing art as "those practical activities directed toward skillful care of patients, and the personal wisdom, insight, and creativity that developed along the way" (p. 269). Katims further declared that nursing art "is the expressive, creative, and intuitive application of formal knowledge" (p. 269). Chinn et al. (1997) defined the art of nursing as

> a synchronous, spontaneous, in-the-moment, and intuitive act, involving the deliberate application of relevant theory, facts, technical skill, personal knowing, and ethical understanding in an attempt to transform the experience of the patient into a realm that would not otherwise be possible. (p. 90)

In summary, nurse scholars compositely referred to the art of nursing as a spontaneous, deliberate, individualized action involving the application of knowledge, judgment, and skill in a particular nursing situation to achieve a particular patient outcome. The establishment of a nurse-patient relationship and a committed stance on the part of the nurse are assumed. In addition to knowledge, judgment, and technical skill, the use of intuition, wisdom, creativity, moral insight, and personal knowledge of both patient and self also contribute to a successful patient outcome and thus also fall under the rubric of nursing art. Although it can be concluded that what has been gleaned from the above definitions of the art of nursing is by no means inclusive of what the literature has revealed about the nature of nursing art or the dimensions of artful practice, this definitional overview does provide some initial insight into this rather elusive concept.

Several different modes of formal inquiry have been used to investigate the nature of the art of nursing, including philosophic, empirical, narrative, and interpretive approaches. Not all of these works use the term "nursing art" or "art of nursing" directly; however, it can be argued that their subject matter is relevant to the art of nursing. For example, works that have explored excellence, expertise, caring, and comforting in nursing practice are included. While I recognize that these topics are not mutually exclusive, their treatment as separate topics is primarily for organizational purposes.

Philosophic Inquiry

The development of scholarly interest in the art of nursing can be largely credited to Carper (1978/1997, 1992) on the basis of her pioneering work on the fundamental patterns of knowing in nursing. One of the purposes of Carper's (1992) philosophical inquiry was to "identify the fundamental patterns of knowing that characterize and exemplify the discipline of nursing" (p. 72). Based on the work of Phenix, she analyzed the nursing literature published within the period 1964-1965 to 1974-1975. Her results revealed four fundamental patterns of knowing in nursing: empirics, the science of nursing; ethics, the component of moral knowledge; personal knowledge; and aesthetics, the art of nursing. My decision to include her work here is validated by the fact that the value of her work lies in the recognition that nurses require knowledge beyond scientific knowledge and that knowledge of the art of nursing (aesthetic knowledge) is central to nursing. Carper's description of aesthetics is as follows:

> This pattern of knowing is knowledge of that which is individual, particular, and unique. Aesthetic knowledge requires the active transformation of what is observed, through the experience of subjective acquaintance, into a direct, non-

> mediated perception of significant relationships and wholes rather than separate, discrete parts. Aesthetic knowledge is the comprehension and creation of value and meaning from both generalized abstractions and concrete particulars. It enables us to 'go beyond' what can be explained by existing principles and theories and to account for variables that cannot be systematically related or quantitatively formulated. It is interpretive, contextual, intuitive, and subjective knowledge. It requires synthesis rather than analysis. (p. 77)

Another philosophical inquiry relevant to the art of nursing is Johnson's (1993, 1994) landmark dissertation. Although this work was referred to earlier, its contribution here is more inclusive of its subject matter. Following the work of Adler, Johnson used a dialectical approach to analyze the discourse in the research of 43 nurse scholars that was published between 1860 and 1992. One of the purposes of her inquiry was to answer the question, What is the art of nursing? The analysis of the literature for points of topical agreement revealed five distinct conceptualizations of nursing art: nursing art as the ability to grasp meaning in patient encounters, nursing art as the ability to establish a meaningful connection with the patient, nursing art as the ability to skillfully perform nursing activities, nursing art as the ability to rationally determine an appropriate course of nursing action, and nursing art as the ability to morally conduct nursing practice. Johnson pointed out that these conceptualizations were constructed from evidence provided in the works of the various nurse scholars and were not theirs per se. She further explained that, although these conceptualizations are mutually exclusive, most nurse scholars addressed more than one conceptualization in their work. Presented below is a brief overview of the analysis that reveals the similarities of thought among nurse scholars regarding each of these conceptualizations.

The ability to grasp meaning in patient encounters. The artful nurse is able to grasp what is significant in a particular patient situation. The capacity to grasp meaning is an immediate perceptual capacity unaffected by the intellect, otherwise known as intuition. Grasping meaning is a holistic capacity, and it results in a form of understanding that is indescribable. The insights gained are tacit, nonpropositional, personal, and, as such, in no way communicable. The meanings that are grasped are concrete and individual, and they pertain to a particular patient situation rather than being abstract and pertaining to patients in general. In an additional sense, the artful nurse is also able to grasp the meaning that health experiences have for the patient from the perspective of the patient and uses this understanding to inform his or her actions on behalf of the patient (Johnson, 1993, 1994).

The ability to establish a meaningful connection with the patient. A meaningful connection between patients and their nurses is considered pivotal to the provision of artful nursing care. This meaningful connection is nonconceptual. The artful nurse expresses this connection only through concrete actions and gestures in response to a particular patient. This meaningful connection is expressive of emotions, sentiments, or the nurse's state of being, occurs in relation to another human being as "subject" rather than "object," and can occur only when the nurse is authentic, genuine, and sincere (Johnson, 1993, 1994).

The ability to skillfully perform nursing activities. The artful nurse demonstrates proficiency and dexterity (skill) in executing nursing tasks, procedures, and techniques. Skillful performance is primarily a behavioral ability; that is, it involves observable actions and focuses on the process of doing rather than knowing. There is no doubt, however, that the nurse's intellectual capacity plays a role. Skillful performance can be honed over time with practice and repetition and can be judged by using a number of criteria such as efficiency, proficiency, fluidity, and harmony (Johnson, 1993, 1994).

The ability to rationally determine an appropriate course of nursing action. Intellectual ability is a key factor in determining an appropriate course of action and thus plays an important role in practical activity. Hence knowledge, especially scientific knowledge, is important to guide artful nursing practice. Logical reasoning is involved in the application of scientific principles to the identified problems. Yet to achieve the best possible outcome, the artful nurse also considers all of the salient aspects of the particular situation in rationally determining an appropriate course of action. Whether the nurse has been successful in achieving the identified goals can be judged according to specific standards (Johnson, 1993, 1994).

The ability to morally conduct one's own nursing practice. The artful nurse seeks to avoid harm and to benefit the patient. Because nurses are involved with seeking what is good or desirable for human beings, artful practice is, by necessity, moral. For artful practice, skills and knowledge are necessary, but they are not sufficient. In artful nursing practice the nurse is committed to care competently, no matter the contingent circumstances. Finally, the artful nurse possesses moral virtue. The artful nurse is motivated by care and concern for others rather than being driven by such motives as self-aggrandizement or expediency (Johnson, 1993, 1994).

Excellence/Expertise in Nursing Practice

In agreement with Johnson (1993, 1994) that nursing art perfects a nurse's practice, a review of the literature relevant to the art of nursing would be incomplete without reference to those inquires related to excellence and expertise in nursing practice. As Cooper (2001) and Hampton (1994) both concluded, expert practice embodies the art of nursing, and thus the study of expert practice has contributed to knowledge relevant to the art of nursing.

The exemplary pioneering and ongoing work of Benner and her colleagues (Benner, 1984, Benner & Tanner, 1987; Benner & Wrubel, 1989; Tanner, Benner, Chesla, & Gordon, 1993; Benner et al., 1996; Benner et al., 1999) is an appropriate point of departure. The principle aim of this work has been to describe the nature of skill acquisition and to articulate the nature of clinical nursing knowledge among expert nurses in critical care settings. This work has been based on the assumption that a wealth of untapped knowledge is embedded in the expert practice of critical care nurses. Their data collection involved interviewing large numbers of critical care nurses, individually and in small groups, from a variety of critical care areas, including neonatal intensive care, as well as observation of smaller numbers as they engaged in critical care nursing practice. Their analysis was based on hermeneutic phenomenology within the tradition of Heidegger and Kierkegaard (Benner, 1984; Benner et al., 1996) as well as descriptive ethnography (Benner et al., 1999), both of which involved interpretive description of narratives of actual practice.

Whereas the work of Johnson (1991, 1996a) emphasized the importance of scientific or theoretical knowledge for expert practice, the work of Benner and colleagues emphasized the importance of practical knowledge (i.e., know-how knowledge vs. know-that knowledge) for expert practice. Benner et al. (1999) contended, "It is not enough to simply know 'that.' . . . The expert practitioner must know 'how' and know when to initiate appropriate interventions based on how the particular patient presents in the clinical situation" (p. 12). Accordingly, the major contribution of this work has been the articulation of the nature of practical knowledge underlying expert nursing practice, particularly in relation to clinical and ethical decision making leading to appropriate interventions. While Benner and colleagues (Benner et al., 1999) did not discount the importance of theoretical knowledge or suggest that expert nurses never use analytic tools, they do opine that practical knowledge is the hallmark of expert critical care nursing practice.

By applying the Dreyfus model of skill acquisition to nursing, Benner and colleagues described the nature of skill acquisition as involving a passage through five levels of proficiency. The various stages are the novice, advanced beginner, competent, proficient, and expert. This passage to expertise is characterized by practical knowledge accumulation that results from experience in actual clinical practice. "Experience is therefore a requisite for expertise" (Benner, 1984, p. 3). According to Benner et al. (1999), experience does not occur without active participation; nor is it guaranteed by the mere passage of time. Rather, "experience results when preconceptions and expectations are challenged, refined, or disconfirmed by the actual situation" (Benner, 1984, p. 3). Given the notion that the expert practitioner best exemplifies the art of nursing, the subsequent description of the nature of practical knowledge focuses on the practical knowledge possessed by the expert critical care practitioner, that know-how that underlies the artful practice of the expert critical care nurse.

In the course of their analysis, Benner and colleagues (Benner, 1984; Benner et al., 1999) also inductively derived what they referred to as competencies of expert critical care nursing practice, which they subsequently classified into domains. Originally, they identified seven domains (Benner, 1984). However, more recent analysis has revealed nine domains (Benner et al., 1999). Benner et al. (1999) pointed out that although "these domains of practice overlap and occur simultaneously, each domain can become central in directing the nurse's attention and work, sometimes capturing high priority while at other times necessarily receding into the background" (p. 2). Considering that practical knowledge is needed to achieve these competencies, a brief overview of these domains of practice provides a logical starting point for the eventual description of the nature of practical knowledge in expert critical care nursing practice as revealed in the work of Benner and colleagues (Benner et al., 1999). This achieved another indirect goal inherent in the literature review, although not previously stated: to provide a broad contextual background for this inquiry. In other words, each domain gives further insight into the context in which critical care is delivered. Thus it also fosters a better understanding of the intellectual and emotional challenges that nurses face in a fast-paced, highly charged environment where life-threatening situations and narrow margins for error dictate quick, astute decision making and rapid responses.

Diagnosing and managing life-sustaining physiological functions in unstable patients. Typically, critically ill or injured patients are either no longer able to independently maintain physiologic stability or are at high risk for rapidly developing physiologic instability. The expert nurse is capable of providing the continuous intensive monitoring and care that are required for diagnosing and managing unstable and often life-threatening physiological conditions, situations, or both (Benner et al., 1999).

Skilled know-how in managing a crisis. Crisis situations, characterized as life-threatening events in which multiple and rapid interventions are required to preserve the life of a patient, are a common occurrence in the critical care unit. Typically, critical care nurses are the first to respond to and manage these situations. The expert nurse is able to diagnose and provide initial emergency treatment, to mobilize assistance from others, and to manage the environment, logistics, and equipment, if need be (Benner et al., 1999).

Providing comfort for the critically ill. For critically ill patients the potential sources of discomfort are many. For example, pain or other bodily discomfort may be associated with pathologic processes, may arise from inflicted sources (e.g., various diagnostic and therapeutic activities), or both. Emotional discomfort may arise from fear, anxiety, unfamiliarity, or loss, to mention a few. The expert nurse is attuned to these sources of discomfort and is able to provide comfort. The expert nurse recognizes that providing comfort is for more than comfort's sake, that it is also crucial to positively influencing the physiological and emotional status of these patients as well as their responses to diagnostic and therapeutic activities (Benner et al., 1999).

Caring for patients' families. With critical illness or injury of a family member, the expert nurse provides care to the family amidst many challenges and demands. The needs of family are many and varied, which is reflected in the growing body of knowledge that specifically addresses the needs of family members of critically ill patients. Because an in-depth discussion of this literature is beyond the scope of this review, suffice it is to say that expert nurses are able to meet family members needs. Examples of such needs include the need for information, support, and reassurance and the need to be present and involved in caring activities (Benner et al., 1999).

Preventing hazards in a technological environment. Whereas the remarkable benefits of the very pervasive and sophisticated technology in the critical care setting cannot be denied, "the use of technology is not without risk, nor is it free from ethical considerations" (Benner et al., 1999, p. 334). The expert nurse is able to prevent both actual and potential hazards in the technological critical care environment (Benner et al, 1999).

Facing death: End-of-life care and decision making. It is in the critical care setting where the quest to "cure" and the heroic fight to maintain life are most prominent. However, amidst heroic efforts, the reality is that patients do die in critical care units. Expert nurses are able to face this inevitability and are prepared to make appropriate clinical and ethical decisions to effectively meet the needs of those facing death (Benner et al., 1999).

Communicating multiple clinical, ethical, and practical perspectives. Expert nurses effectively create a climate that facilitates a common understanding of the clinical, ethical, and practical issues surrounding the care of the critically ill to achieve the best possible outcomes for patients. To ensure that they make sound clinical and ethical decisions, expert nurses are able to create a communicative climate for everyday clinical problem solving and teamwork by helping to resolve the ambiguities and communication difficulties among team members, including patients and families (Benner et al., 1999).

Monitoring quality and managing breakdown. The fast-paced, highly charged critical care environment is by nature susceptible to breakdown. The expert nurse is able to effectively manage the breakdown that occurs in the care of patients arising from such sources as the lack of collaborative function among team members, the lack of essential resources, problems with the system at large, or any combination of these three. Given that the critical care environment is an imperfect one, the expert nurse is involved in monitoring and improving quality as well as successful in managing breakdown so that the best possible outcomes for patients and families are achieved rather than compromised (Benner et al., 1999).

The skilled know-how of clinical leadership and the coaching and mentoring of others. Expert nurses are strong relational and clinical leaders. They assist in team building. They "envision realistic possibilities for improvement and/or development in their own and others' performance" (Benner et al., 1999, p. 490). They are skilled in the teaching and coaching of others. Expert nurses also realize that taking a stand on patients' behalf is often required to provide excellent care to critically ill or injured patients (Benner et al., 1999).

Given the characteristics of expert nurses in each of the domains of critical care nursing practice, the question regarding the nature of the practical knowledge that underlies the clinical and ethical decision making and appropriate actions of expert nurses remains. As gleaned from the work of Benner and colleagues (Benner et al., 1996; 1999), experts have developed intuitive knowledge and knowledge of the good and right as well as the existential skill of involvement and embodied intelligence. Although these aspects of knowledge can be distinguished, in actual clinical situations they are used in synergy.

Intuitive knowledge. Intuition is considered a legitimate and essential aspect of expert clinical and ethical decision making in critical care nursing practice (Benner & Tanner, 1987). Benner and Tanner defined intuition as "understanding without a rationale" (p. 23). Although analytical reasoning and intuition "can and often do work together" (p. 31), the expert nurse no longer relies as heavily on analytic reasoning to judge and respond to a clinical situation. Instead, the expert nurse, with an enormous background of experience, relies on an intuitive grasp of the situation, a direct apprehension of the whole situation in which only certain aspects are salient.

Intuition is supported by previous experiences with similar situations, particular patient populations, or both. As a result of their experiences, expert nurses are able to recognize patterns and subtle trends, make qualitative distinctions, know what has worked in the past, and see the unexpected. All of these aspects modified in accordance with "knowing the patient" (Tanner et al., 1993, p. 273) enhance intuitive knowledge and, in turn, effectively shape the clinical and ethical decision-making process. The phenomenon of knowing the patient means knowing the patient's patterns of responses (i.e., to therapeutic measures, routines and habits, coping resources, physical capacities and endurance, and body typology and characteristics) and knowing the patient as a person (Benner et al., 1996; Tanner et al., 1993).

Knowledge of the good and right. Expert nurses have a disposition toward what is good and right, which sets up what they notice and how they respond in particular situations. According to Benner et al. (1996), this disposition "is not a matter of individual ethics, but is rather socially constructed and embedded within the discipline as well as within the norms and mores of the particular unit on which they practice" (p. 15). Furthermore, this disposition "is not principle based, in the sense of rules or precepts which nurses can make explicit and which are generalizable across situations," nor are they "totally particularistic, subjective, and private" (p. 15). Rather, there are common goods that shape nurses' perceptions of, and responses to, particular clinical situations that provide essential guidance in clinical and ethical decision making. They include "the intention to humanize and individualize care, the ethic of disclosure to patients and families, and the importance of comfort in the face of extreme suffering and impending death" (p. 6).

Existential skill of involvement. Expert nurses have developed the skill of involvement, "the skill of getting an open and attentive engagement with the clinical situation or problem and the skill of getting the right amount of interpersonal engagement with the patient and family" (Benner et al., 1999, p. 16). The right level of involvement rather than over- or underinvolvement, is contextual and serves to maximize perceptual acuity in the clinical and human situation. Accordingly, this increased perceptual acuity leads to sound clinical and ethical decision making. With the skill of involvement, expert nurses better understand patients' wishes, which creates more possibilities for advocacy (Benner et al., 1996).

Embodied intelligence. Experts have the embodied skills and ways of being with patients that are required for the skilled performance of tasks, procedure, and techniques (e.g., conducting physical assessment, performing body care, comforting, initiating various therapeutic interventions, and managing technology). This skilled know-how "refers to not only what to do and when to do it; it is knowing how to do what is needed" (Benner et al., 1999, p. 570). There is a "bodily takeover" (Benner & Wrubel, 1989, p. 53) of the skill that enables reliable emotional and physical responses, comportment, organization, and appropriate timing in reaction to patients' responses or particular situations (Benner et al., 1996). It is the fine-tuning of a skill that cannot be achieved by simply reading procedural manuals, but rather by learning through observing other practitioners and patients' responses over time as expert nurses practice the skill (Benner et al., 1996).

In summary, critical care nurses work in a complex and demanding technological environment where astute clinical and ethical decision making and skilled performance are vital to achieving positive patient outcomes. The work of Benner and colleagues (Benner, 1984, Benner & Tanner, 1987; Benner & Wrubel, 1989; Tanner, Benner, Chesla, & Gordon, 1993; Benner et al., 1996; Benner et al., 1999) has made an invaluable contribution to our understanding of the expectations placed on critical care nurses, as well as the practical knowledge required in meeting them. As a result, Benner and her colleagues have given legitimacy to practical knowledge—the recognition that it has not previously received given the predominating Western traditional view on what constitutes knowledge. Although know-that knowledge is important for clinical and ethical decision making and skilled performance, it is know-how knowledge, accumulated through experience, that is at the heart of expert critical care nursing practice. Intuitive knowledge and knowledge of the good and right, as well as the skill of involvement and embodied intelligence, together contribute to the decision-making process and the subsequent actions that the expert nurse takes in the particular situation. However, whereas the nature of clinical nursing knowledge that underlies expert critical care nursing practice has been illuminated by this work, the nature of nursing art in critical care nursing practice is less visible.

By contrast, Cooper (2001) and Perry (1994, 1998) provided more in-depth explications of the nature of nursing art, and therefore their work more closely resembles the nature of this inquiry. Accordingly, a fairly extensive review of their research is also warranted.

Cooper (2001) conducted a form of narrative inquiry into the nature of expert practice with the intent of portraying the diversity and richness embodied in the artful practice of nurses and highlighting the types of nursing knowledge that underlie expert practice. She distinguished between general (empirical) knowledge and particular knowledge and devoted considerable attention to describing personal and ethical knowledge. She also described the general aspects of skill acquisition. However, because much of her description of nursing knowledge is based on the previous work of Carper (1978/1997, 1992) and Benner and her colleagues, (Benner, 1984, Benner & Tanner, 1987; Benner & Wrubel, 1989; Tanner, Benner, Chesla, & Gordon, 1993; Benner et al., 1996; Benner et al., 1999) this aspect of her work will not be reiterated here.

In her portrayal of the art of nursing, Cooper (2001) featured the narratives of 10 expert nurses from a variety of settings and depicted seven central concepts that represent commonly identified themes in artful nursing practice: care for patients, advocacy for patients, advocacy for populations, support for spirituality, the response of compassion, the presence of the nurse, and care for oneself. She discussed each concept as it was actualized in the narratives and subsequently fortified her discussion by using relevant and supporting nursing literature. A brief summary of these concepts, with one exception, is outlined below. I have omitted the concept of advocacy for populations on the premise that its focus on community health nursing extends beyond the boundaries of this review.

Caring for patients. Caring for patients arises from a desire to relieve the loneliness and suffering of a fellow human being. Nurses' skilled actions of care have the power to transform the fear and pain and suffering of patients into a tolerable, shared experience. The knowledge required for such care extends beyond scientific and technical knowledge to include knowledge of the patient, the self, and the encounter between the self and the patient—the kind of knowledge that is acquired through experience and practice. Caring encounters involve a choice to become involved, a focus on patient needs, and active and individualized responses to those needs. Although caring encounters vary in their intensity, duration, and frequency, they all involve a way of being that arises from the recognition of the fundamental connection or interdependence among all persons.

Advocacy for patients. Advocacy can take many forms, depending upon the values and needs of the patient. Fundamentally, advocacy entails advising patients of their rights, providing information so that they can make informed decisions, and then supporting those decisions. Advocacy also helps patients to clarify their values and make decisions that are compatible with these values. Thus, it helps them to preserve their identity and uniqueness as well as maintain their personal integrity. Advocacy basically involves focusing on the patient, being aware of the patient's rights, and honoring the patient's values.

Supporting spirituality. Recognizing and responding to patients' spiritual needs are vital though subtle and challenging features of the art of nursing that require that nurses be aware of and sensitive to the spiritual aspects of their experience and set aside their assumptions of truth based on their own personal religious beliefs. Although spiritual care must be unique and fit the situation, it generally includes honoring patients' expressions of spirituality, supporting their beliefs and rituals, and helping them to discover answers to questions of meaning. In most cases the goal of spiritual care is to temper the spiritual pain and isolation that accompany illness and loss.

Response of compassion. Compassion, as the touchstone of the art of nursing, entails recognizing patient suffering, entering into the patient's experience, and having the desire to act to relieve a patient's suffering. Nurses' acts of compassion may take multiple forms, ranging from advocacy to simply opening themselves to patients' suffering, and require courage, commitment, and some emotional investment. Yet compassion also offers the nurse the affirming experience of deeply sharing a common human experience.

The presence of the nurse. Presence occurs when the nurse engages with the patient in a receptive manner with the intent of meeting all of the patient's needs. It involves openness and a willingness to enter the patient's experience and thus is considered to be the highest level of human caring. Presence may be in the form of listening, touching, or attentively giving physical care and results in feelings of trust, connection, and hope, all of which can help to mitigate the isolation of suffering or provide relief from despair.

Caring for oneself. Despite the many professional and personal challenges that might exist to threaten caring for oneself in nursing, self-care is vital to effectively caring for others and to growing in one's professional role. Artfully caring for oneself means that nurses must be fully aware of the challenges and joys in nursing, cognizant of their strengths and limitations, and realistic in their expectations of themselves and their professional role. The artful caring of oneself also involves taking a proactive and positive approach to their work and seeking ample opportunities for affirming and satisfying nurse-patient encounters.

The merit of Cooper's (2001) work lies in her use of narratives to portray the complexity and skill required for artful nursing, her emphasis on the need for the engagement of the nurse for artful practice, her inclusion of the art of caring for oneself as an important factor in artful nursing, and her open discussion of the obstacles to enacting artful nursing. However, consistent with much of the current nursing literature, several of the concepts used to depict artful nursing practice are competing concepts (Morse, 1995)—for example, compassion and presence—and thus somewhat limit the breadth and depth of understanding of artful nursing practice.

Perry (1994, 1998) conducted a hermeneutic phenomenological/grounded theory inquiry into the nature of exceptionally competent nursing practice among expert oncology and palliative care nurses in an adult setting. The data sources for her work included both interview and observation of nurses engaged in practice. Her analysis involved interpretive description of narratives of actual practice and poetic interpretation. Consistent with the evidence revealed in the work of Benner and her colleagues (Benner, 1984; Benner & Tanner, 1987; Benner et al., 1999; Benner et al., 1996; Tanner et al., 1993), Perry (1998) described "exceptional" nursing practice as involving more than technical competence. Although the nurses were described as being technically competent, their exceptional competence, as revealed in their actions and interactions, was influenced by a high degree of self-awareness and their underlying values and beliefs. For these nurses, their "well developed nursing philosophies became their blueprints for action" (p. 155). Important elements of these philosophies include a reverence for life; respect for the dignity, worth, autonomy, and individuality of each individual; a commitment to helping patients attain the highest quality of life possible; and acceptance of death as a natural part of life. A distinguishing quality of their actions and interactions was a sharing of parts of themselves with patients and allowing patients to share themselves with the nurses. For these exceptionally competent nurses, their work was a great source of motivation and satisfaction.

The themes around which Perry (1994, 1998) interpretively described exceptionally competent nursing practice were the dialogue of silence, mutual touch, and the sharing of the lighter side of life. A brief summary of these themes is outlined below.

The dialogue of silence. Exceptionally competent nurses use silence appropriately in a variety of circumstances; for example, when all that needs to be spoken has been said, when they care for patients from different cultures, when the patient receives bad news, when they care for the cognitively or psychologically impaired, when they care for dying patients, in situations where words are unnecessary, or when there are no suitable words. Shared silence provides for a presence that furnishes patients with a sense of emotional and physical safety as well as the feeling that they are understood, valued, and not alone. Shared silence also facilitates listening with openness, which means a preparedness to receive the patient's messages and remain open to being changed by the communication. At times silence is used alone; at other times it may be combined with appropriate touch.

Mutual touch. According to Perry (1994, 1998), touch by nature is reciprocal; it affects both the person initiating the touch and the person being touched. She also suggested that the positive effects of touch are enhanced when it is accompanied by silence and eye contact. Exceptionally competent nurses use touch as an extension of presence and to express their involvement in the patient's experience. Exemplary nurses also use touch to decrease patient anxiety and isolation, which helps the patient to feel safe, valued, reassured, and comforted. Perry (1994, 1998) identified and described eight types of touch that exemplary nurses use: procedural touch, nonphysical touch, talking touch, trigger touch, social touch, diagnostic touch, comforting touch, and the final touch.

The sharing of the lighter side of life. Exceptionally competent nurses commonly approach life with a light-hearted attitude and share this appropriately and effectively with their patients. They deliberately choose to see the positive and humorous side of situations amidst what are often tragic circumstances. Laughter and humor are major components of this light-hearted attitude and serve to provide communicative, social, psychological, and therapeutic functions. Exemplary nurses use various forms of humor that have been interpreted and described as surprise humor, word-play humor, black humor, situational humor, and divergent humor.

In addition to the interpretive description of exceptionally competent nursing practice, Perry (1994, 1998) also offered an interpretive description of the effects of exemplary nursing care. The themes around which she described these effects are connecting, affirming the value of the patient, affirming the value of the nurse, and joint transcendence. A brief summary of these themes is outlined below.

Connecting. Exemplary nursing care enables the development of a connection between the nurse and patient. Perry (1994, 1998) described connecting as a process of attachment or bonding between a nurse and patient. One component of the development of this connection is the mutual recognition of their similarities. An important prerequisite to and part of connecting is the ability to envision the patient as he or she was before becoming ill. A third component in establishing this connection involves the nurse's participation in the patient's experience.

Affirming the value of the patient. The use of silence, touch, and light-heartedness helps to make patients feel important and valued. Through their actions and interactions, nurses can assure their patients that no matter how unwell they are, they are still important. Nurses affirm the value of their patients by letting them know that they will be remembered after death, helping them to find meaning in their experience, treating them with respect, maintaining their dignity, and helping them to find and maintain hope.

Affirming the value of the nurse. In providing care to their patients, nurses come to know that they are making a difference in the lives of their patients. Like patients, nurses too are able to find meaning in their experiences. So too do nurses' actions and interactions affirm themselves just as they do their patients, and they too come to feel important and valued.

Joint transcendence. An overall effect of exceptional nursing practice that involves both patient and nurse is what Perry (1994, 1998) called joint transcendence. Unable to find the words to adequately describe this phenomenon, Perry (1994) attempted to express the meaning of joint transcendence through writing a poem entitled "Shared Journey." It is included here to fulfill the purpose for which it was intended, but also for its value in capturing some of the meaning that this overview of the nature of exceptionally competent nursing practice failed to do.

Shared Journey

Together,
nurse and patient
rise above the pain,
suffering,
and despair
of cancer,
and climb to the top of the mountain that
has no summit.

They take turns
carrying one another.
For they know that neither
can make it alone.

In their time together,
they share through touch,
silence,
and lightheartedness.

In their time together,
they learn about themselves,
their needs,

their strengths,
their limitations.

But most important of all
they learn about their similarities.

They both share the common fate
of mortality,
an understanding which makes
the pleasures of life more intense.

They both possess the potential
for knowing joy,
awe,
and wonder.

They both can understand
that though the body
may be diseased,
disfigured,
distasteful,
the spiritual body can be healthy,
beautiful,
and whole.

Through the intimacy of their
relationship they discover
they are valued,
they are worthwhile,
that they can,
and do,
make a difference.
Each, in their own way,
creates meaning out of their experience.

As they reach
higher and higher planes
the patient may leave
to take up challenges elsewhere,
while the nurse,
having gained strength
from the journey
is able to carry on. (pp. 300-301)

Whereas Perry's (1994, 1998) interpretive-descriptive work makes a significant contribution to the understanding of the nature of nursing art, it is within the context of oncology and palliative care nursing practice. Given the different contextual nature of the critical care environment (e.g., the presence and role of technology) and patient population (e.g., life-threatening illness vs. terminal illness), intuitively, it becomes apparent that although there are likely to be common dimensions of artful nursing practice, there are also likely to be inherent differences.

Caring in Nursing Practice

On the basis that some scholars equated the art of nursing with caring (Chinn & Watson, 1994; Watson, 1988, 1997), this literature too is considered relevant to the art of nursing. Over the past two decades a great deal of research has been directed toward explicating the nature of caring in nursing practice. Although a plethora of quantitative studies have been conducted, I have intentionally omitted these studies from this review on the premise that they do little to inform the conceptual background for this inquiry. Support for this position is evident in Benner and Wrubel's (1989) similar conclusion that "the language of positivistic social science and the natural sciences are too impoverished to give an adequate account of what actually occurs in everyday life" (p. 41). As well, these quantitative studies have not addressed the positive patient outcomes of caring. Accordingly, only those inquiries that employed qualitative methods are included (i.e., content analysis, grounded theory, phenomenology, and hermeneutic phenomenology).

One underlying assumption evident in much of this qualitative work has been scholars' adoption of Leininger's (1981) position that "caring is the central and unifying domain for the body of knowledge and practices in nursing" (p. 3). Another assumption is that the concept of caring remains underdeveloped and inadequately explicated, an assumption that many have drawn on the work of Morse and her colleagues (Morse, Bottorff, Neander, & Solberg, 1991; Morse, Solberg, Neander, Bottorff, & Johnson, 1990) who, after reviewing authors' definitions and perspectives of caring, identified five distinct conceptualizations of caring: caring as a human trait, a moral imperative, an affect, an interpersonal interaction, and a therapeutic intervention.

After reviewing the qualitative studies directed toward elucidating the nature of caring in nursing, I have drawn several conclusions. The first is that a great deal of confusion exists in this literature. For example, different themes/categories have been used to describe the same idea, or the same theme/category has been used to describe different ideas. As well, the reports of findings range from very specific descriptions to broad generalizations about caring. Last, this body of work is, as a whole, more descriptive than interpretive. Accordingly, this comprehensive review of the qualitative work on caring in nursing is descriptive in nature.

For the sake of brevity, this literature will be integrated and presented according to a framework that I have adapted from Montgomery (1993). As well, this integrated review encompasses the perceptions of expert nurse caring from the perspectives of both expert nurses and patients without distinction and includes only those studies conducted in adult acute and critical care settings.

The predispositional qualities of caring nurses. Montgomery (1993) defined *predispositional qualities* as "an existential way of being in relation to others" (p. 41). Caring nurses are oriented towards patients as whole persons and use their humanness to become engaged with patients (Montgomery, 1993). They are willing to share part of their personal selves with patients (Åström, Norberg, Hallberg, & Jansson, 1993, 1995; Jenny & Logan, 1996; Miller, Haber, & Woods-Byrne, 1992). Caring nurses show concern for the human element in health care and recognize human wholeness, individuality, and integrity as well as the fragility and vulnerability of patients in the technological environment of health care (Appleton, 1993, 1994; Lovgren, Engstrom, & Norberg, 1996; Montgomery, 1993; Wilken & Slevin, 2004). They are committed to helping—a commitment that goes beyond what is dictated by the medical/technical agenda (Montgomery, 1993; Morrison, 1991). Caring nurses are nonjudgmental; they are accepting of patients who do not share the same values or who make different choices (Montgomery, 1993).

Caring nurses are able to find positive meanings, possibilities, and hope even in the most tragic of circumstances (Forrest, 1989; Miller et al., 1992; Montgomery, 1993; Sherwood, 1991; Swanson, 1993). As a result of this positive orientation, they maintain the courage they need to become and remain involved in their patients' lives (Jensen, Back-Pettersson, & Segesten, 1993, 1996; Montgomery, 1993). Caring nurses participate fully and appropriately in their patients' experiences without the need for ego gratification (Montgomery, 1993; Morrison, 1991).

The relational qualities of caring nurses. Caring nurses are able to establish a deep, meaningful connection with patients (Åström et al., 1993, 1995; Burfitt, Greiner, Miers, Kinney, & Branyon, 1993; Chinn et al., 1997; Jensen et al., 1993, 1996; Kralik, Koch, & Wotton, 1997; Miller et al., 1992; Montgomery, 1993; Ray, 1987). They are open and honest in their communication (Appleton, 1993; Warren, 1994). They make an effort to remain positive and cheerful (Kralik et al., 1997; Lovgren et al., 1996) and to be involved in a personal way, often using humor (Kralik et al., 1997; Lovgren et al., 1996) or displaying affection (Montgomery, 1993).

Caring nurses communicate "presence," that they are "there" for their patients (Appleton, 1993, 1994; Åström et al., 1993, 1995; Beck, 1993; Beeby, 2000; Burfitt et al., 1993; Clark & Wheeler, 1992; Euswas, 1993; Forrest, 1989; Gramling, 2004; Green-Hernandez, 1991; Jensen et al., 1993, 1996; Miller et al., 1992; Montgomery, 1993; Ray, 1987; Reimen, 1986; Sherwood, 1991; Swanson, 1993; Wilken & Slevin, 2004). This presence is evident in their genuine communication (Kralik et al., 1997; Montgomery, 1993; Morrison, 1991) and their compassion (Appleton, 1993, 1994; Burfitt et al., 1993; Jensen et al., 1993, 1996; Kralik et al., 1997; Miller et al., 1992; Ray, 1987; Sherwood, 1991).

Caring nurses are sensitive to, acknowledge, and respond appropriately to patients' feelings (Appleton, 1993, 1994; Bush & Barr, 1997; Montgomery, 1993; Sherwood, 1991). They are empathic and "understand" patients' experiences (Appleton, 1993, 1994; Åström et al., 1993, 1995; Beeby, 2000; Bush & Barr, 1997; Euswas, 1993; Forrest, 1989; Miller et al., 1992; Morrison, 1991; Ray, 1987; Sherwood, 1991; Swanson, 1993; Wilken & Slevin, 2004). As a result, they are able to provide reassurance and emotional support (Beck, 1993; Beeby, 2000; Brown, 1986; Burfitt et al., 1993; Bush & Barr, 1997; Clarke & Wheeler, 1992; Green-Hernandez, 1991; Jenny & Logan, 1996; Sherwood, 1991; Swanson, 1993; Wilken & Slevin, 2004).

The behavioral qualities of caring nurses. Through the skillful performance of nursing interventions, caring nurses demonstrate confidence and competence (Beck, 1993; Brown, 1986; Burfitt et al., 1993; Bush & Barr, 1997; Chinn et al., 1997; Green-Hernandez, 1991; Jensen et al., 1993, 1996; Kirk, 1993; Lovgren et al., 1996; Miller et al., 1992; Montgomery, 1993; Sherwood, 1991; Swanson, 1993; Warren, 1994; Wilken & Slevin, 2004). Caring nurses are sensitive to patients' needs and often able to anticipate patients' needs in advance (Kralik et al., 1997; Montgomery, 1993). Caring nurses are willing to help or "do for" patients as needed (Euswas, 1993; Green-Hernandez, 1991; Lovgren et al., 1996; Swanson, 1993), but also to take time to do the "little extras" (Brown, 1986; Burfitt et al., 1993; Green-Hernandez, 1991; Kirk, 1993; Kralik et al., 1997; Montgomery, 1993; Sherwood, 1991). Caring nurses recognize the value of patient involvement in decision making and in their own care (Miller et al., 1992; Montgomery, 1993). However, even when nurses are not "doing for" their patients, they still let their presence be known by just listening (Green-Hernandez, 1991; Jensen et al., 1993, 1996; Lovgren et al., 1996), letting patients know of their availability, or being vigilant (Brown, 1986; Burfitt et al., 1993; Green-Hernandez, 1991).

Caring nurses attempt to maximize patients' physical comfort (Åström et al., 1993, 1995; Brown, 1986; Drew, 1986; Kirk, 1993; Miller et al., 1992; Ray, 1987; Sherwood, 1991; Swanson, 1993; Wilken & Slevin, 2004) and avoid imposing unnecessary discomfort through gentle handling (Kralik et al., 1997). They appropriately and effectively use touch to express caring (Beck, 1993; Bush & Barr, 1997; Clark & Wheeler, 1992; Forrest, 1989; Green-Hernandez, 1991; Kralik et al., 1997; Ray, 1987; Sherwood, 1991; Warren, 1994; Wilken & Slevin, 2004).

Caring nurses are able to mobilize needed resources on their patients' behalf (Montgomery, 1993). Caring nurses are strong advocates for patients (Bush & Barr, 1997; Jenny & Logan, 1996; Jensen et al., 1993, 1996; Montgomery, 1993; Wilken & Slevin, 2004), even if it involves taking confrontational risks (Bush & Barr, 1997; Jensen et al., 1993, 1996; Montgomery, 1993). Caring nurses attempt to meet the informational needs of patients by explaining, coaching, or teaching (Appleton, 1993, 1994; Brown, 1986; Burfitt et al., 1993; Bush & Barr, 1997; Clark & Wheeler, 1992; Forrest, 1989; Green-Hernandez, 1991; Kirk, 1993; Kralik et al., 1997; Miller et al., 1992; Morrison, 1991; Sherwood, 1991; Swanson, 1993; Warren, 1994; Wilken & Slevin, 2004).

The effects of caring on patient outcomes. In general, caring has been described as an important factor in patients' recovery (Bush & Barr, 1997; Drew, 1986; Sherwood, 1993; Warren, 1994) and healing (Burfitt et al., 1993; Green-Hernandez, 1991; Montgomery, 1993; Sherwood, 1993). However, most of the outcomes associated with caring have been described in more specific terms.

As a result of caring, patients feel accepted (Drew, 1986; Jensen, 1993, 1996; Sherwood, 1993), affirmed (Jensen et al., 1993, 1996), respected (Forrest, 1989; Jenny & Logan, 1996; Jensen et al., 1993, 1996; Lovgren et al., 1996; Sherwood, 1993), or important and valued (Forrest, 1989; Jensen et al., 1993, 1996; Montgomery, 1993; Sherwood, 1993). Knowing that they are receiving competent care enhances trust

(Miller et al., 1992; Warren, 1994) and confidence (Kirk, 1993; Lovgren et al., 1996; Sherwood, 1993; Warren, 1994); patients feel less vulnerable (Appleton, 1993, 1994), safe, more relaxed, and confident (Burfitt et al., 1993; Drew, 1986; Kirk, 1993, Lovgren et al., 1996; Sherwood, 1993). Caring enhances patients' self-esteem (Miller et al., 1992) and preserves their autonomy (Brown, 1986; Jensen et al., 1993, 1996) and dignity (Sherwood, 1993, Swanson, 1993). Caring inspires patients' hope (Jensen et al., 1993, 1996; Lovgren et al., 1996; Montgomery, 1993), promotes self-integrity (Montgomery, 1993), develops courage (Jensen et al., 1993, 1996), and improves their ability to cope with adversity (Drew, 1986; Sherwood, 1993; Warren, 1994). Caring enables patients to find meaning in their experiences (Jensen et al., 1993, 1996; Montgomery, 1993) and increases patients' knowledge of themselves (Jensen et al., 1993, 1996). It fosters personal growth (Euswas, 1993) and empowers patients to continue to care about and for themselves (Miller et al., 1992; Montgomery, 1993).

The effects of caring on nurses. Caring seems to be an intrinsically rewarding experience for nurses. It is a source of great satisfaction for them (Åström et al., 1993, 1995; Beck, 1993; Bush & Barr, 1997; Miller et al., 1992) and provides the motivation for them to care further (Åström et al., 1993, 1995; Bush & Barr, 1997). Caring gives meaning to nurses' lives (Green-Hernandez, 1991), is empowering (Montgomery, 1993), enhances their confidence and self-esteem (Beck, 1993; Montgomery, 1993), and promotes their personal growth and self-actualization (Euswas, 1993). Montgomery poignantly summarized the effects of caring on nurses in her conclusion that "caring seems to have an alchemical quality, an energizing effect on the caregiver that might be described as a peak experience, one that creates meaning and reinforces commitment" (p. 99).

Comforting in Nursing Practice

Comfort has been viewed as a critical value inherent in the practice of nursing throughout its history (McIlveen & Morse, 1995). Although comfort has been, and continues to be, a desired outcome in the provision of nursing care (McIlveen & Morse, 1995), attempts to understand comfort and comforting have been slow to emerge. According to Morse (1999), "Comfort has always been somewhere in the heart of nursing, but little attention has been given to its investigation" (p. 394). Within the last decade, however, a body of research directed toward explicating the concept of comfort has been growing. Within this work, various nurse scholars (Kolcaba, 1995a, 1995b, 2003; Morse, DeLuca-Havens, & Wilson, 1997) have suggested that providing comfort falls within the realm of nursing art.

In much of the literature, for example, as evidenced in the above review of the research literature on caring, comfort typically has been conceptualized as the absence or reduction of pain or other physical discomforts (Kolcaba, 1992; Morse, Bottorff, & Hutchinson, 1994, 1995). However, the more recent work of scholars who specifically focus on the concept of comfort revealed that comfort has been conceptualized much more broadly and holistically (Arruda, Larson, & Meleis, 1992; Bottorff, Gogag, & Engelberg-Lotzkar, 1995; Cameron, 1993; Hamilton, 1989; Hawley, 2000b; Kolcaba, 1992, 1994, 1995a, 1995b, 2003; Morse, 1992, 1996b, 2000; Morse et al., 1994, 1995; Morse et al., 1997; Siefert, 2002; Walters, 1994). For example, Kolcaba (1994) defined comfort as "the satisfaction (actively, passively, or co-operatively) of the basic human need for relief, ease, or transcendence arising from health care situations that are stressful" (p. 1178). Kolcaba (1992, 1994, 1995a, 1995b, 2003) explained that comfort occurs in four contexts: namely, the physical, psychospiritual, environmental, and social. According to Morse (1992), comfort is "a state of well-being that may occur during any stage of the illness-health continuum" (p. 93). Furthermore, Morse identified two comfort states: a temporal state such as the temporary relief of pain, and a more constant, long-term state such as the attainment of health or a peaceful death. Implied in both of these definitions is the view that comfort is a higher order construct (Kolcaba, 1992; Morse, 1992).

Morse (1992) contended that "the ultimate purpose of nursing is to promote comfort for the patient rather than to care for the patient" (p. 92). According to Morse

(1983), offering comfort includes nursing actions that range from providing comfort measures for the patient to those that support the patient's own attempts to achieve comfort. As well, the domain of comfort includes those intermediate pain-inducing actions (e.g., giving an analgesic by injection) that are carried out to achieve an ultimate goal: to attain comfort (Morse, 1992). It also includes providing comfort to the dying patient.

In contrast to the research literature on caring in which comfort is considered an aspect of caring, Morse (1992) contended that comfort should remain the overriding construct. On the basis of earlier work that explored various conceptualizations of caring, Morse et al. (1990) and Morse et al. (1991) found agreement only in that caring is an affect—a feeling of concern or a moral responsibility for others—that motivates nursing actions. As such, caring does not encompass the entire domain of nursing. Although Morse did not dispute that caring is an important component of nursing practice, she viewed the promotion of comfort as encompassing more of what nurses actually do. Accordingly, "providing comfort incorporates the concept of caring and the procedural tasks performed by the caregiver" (p. 93). Given this perspective, "caring remains as the affect or feeling of moral responsibility that motivates nursing actions and the affect that is present during the process of comforting, providing the humanistic component of the nursing task or procedural actions" (pp. 93-94). Caring is therefore considered essential to the attainment of comfort and as Morse suggested, necessary if nursing tasks are to be therapeutic.

Much of the formal inquiry related to the concept of comfort to date has been conducted by Morse and colleagues (McIlveen & Morse, 1995; Morse, 1983, 1992, 1996b, 1999, 2000; Morse et al., 1994, 1995; Morse et al., 1997; Morse & Proctor, 1998; Penrod, Morse, & Wilson, 1999; Proctor, Morse, & Khonsari, 1996; Solberg & Morse, 1991). Over the last decade Morse and colleagues have explored various dimensions and forms of comfort and comforting using methods such as phenomenology, grounded theory, concept development, nonparticipant observation, linguistic analysis, and qualitative and quantitative ethology.

In an ethnoscientific analysis of comfort that involved healthy subjects, Morse (1983) identified the components of comfort as touching, talking, listening, or various combinations of these actions. Touching and talking were considered major components, and listening was a minor component. Each of these components was found to have distinct and unique characteristics according to the relationship between the comforter and the person being comforted and the perceived need of the person. For example, touching was used alone if the person was perceived to be feeling afraid, or touching with some talking was used if the person was in pain. In extending this preliminary work to explore the comfort strategies used by nurses, Morse selected the emergency room (ER) reasoning that, in this setting, patient discomfort would be maximized and comforting efforts would be more evident. As a result, much of the research that has focused specifically on the comfort strategies used by nurses has been conducted in this setting (Morse, 1992; Morse & Proctor, 1998; Penrod et al., 1999; Proctor et al., 1996).

In a nonparticipant observational study, Morse (1992) explored the comforting role of ER nurses. Eight types of comforting emerged and were described as "keeping things cool"; "clicking through the assessment"; "watching over," monitoring, and observing patients; helping patients retain/regain control and providing care within the patient's own comfort level; "talking them through it"; reaching the person in the body; keeping the doctors "on track"; and bringing in and supporting the family (pp. 100-103). As in Morse's 1983 study, the comforting strategies of touch and talking were particularly evident. For example, "for patients who were scared, talk was soothing and reassuring, and touch took the form of stroking or patting the patient" (p. 102). On the other hand, "terrified patients were held firmly and talked to in short sentences" (p. 102).

Considering the results of this work with the results of later work that also involved linguistic analysis reveals a composite overview of the provision of comfort by ER nurses. Nurses use comfort strategies directly in response to particular patient signals of discomfort or cues of distress or indirectly by attending to environmental clues. Thus, the comforting process is patient led. Although nurses may also provide comfort proactively in anticipation of pain, this is less frequently the case (Morse, 1996b). Nurses either intentionally or intuitively assess patients for behavioral "cues" that indicate discomfort and search for environmental "clues" that contribute to the discomfort. Because it is the nurse who decides which comfort strategies are to be used for a particular patient, the comforting process is nurse controlled and distinct for the patient's state. Comfort strategies offered by nurses may be independent, ranging from touching and talking to interventions such as positioning, or they may be collaborative such as the administration of medically prescribed analgesics. Strategies may be transient (e.g., a sympathetic verbal response) or occur over a longer duration (e.g., listening with empathic silence). They may be premeditated or occur reflexively without the nurse's awareness. They may be direct (i.e., provided directly to the patient) or indirect (i.e., provided by environmental manipulation). Direct strategies include touching, talking, listening (Morse, 1992), and posturing (e.g., positioning him-/herself in close proximity to the patient's face, with the nurse's face aligned with the patient's in an "en face" position) (Morse & Proctor, 1998; Proctor et al., 1996). Indirect strategies may include hiding concern; cleaning up the environment; controlling when the physician shall see the patient and what treatments will be ordered, including analgesics; supporting the family or allowing the presence of family; and so on (Morse, 1992). Nurses constantly assess the effectiveness and efficacy of their comforting strategies and alter their strategies as needed until a tolerable level of comfort is achieved.

Although some comfort strategies are acquired through formal nursing education, they are primarily acquired informally through experience in nursing practice (Morse et al., 1997). By observing experienced nurses, by learning over time through observing patient responses in the context of the situation, or both, nurses learn which strategies are effective or ineffective, welcome or unwelcome (Morse et al., 1997). Nurses, then, through experience, "learn which strategies to use, when to use them, and with which particular patient cues and situational clues they are appropriate" (p. 333). With experience, nurses also develop an extensive array of comforting strategies from which they develop their own repertoire of preferred strategies (Morse et al., 1997). They also develop different sets or unique combinations of comforting strategies to effectively comfort different types of patients (e.g., patients who are frightened or in pain, anxious patients).

In the case of ER patients, Morse and colleagues (Morse, 1992; Morse & Proctor, 1998; Penrod et al., 1999; Proctor et al., 1996) described the overall goal of providing comfort as enabling patients to endure so that care can be provided with maximal efficiency and safety. In the nonparticipant phase of this work, the most important comfort strategy for achieving this goal is comfort talk, a strategy that had not been previously identified. In brief, "comfort talk is distinguished by the slow rate of speech, clearly marked utterance boundaries; short, simple sentences; and characteristic intonations that gives speech a clear rhythmic pattern and a sing-song quality" (Morse & Proctor, 1998, pp. 216-262). "The speech also has a high frequency of tag questions accompanying interrogatives, associated with the nurse's need to obtain feedback from the patient" (p. 262).

In a later phase of this work, the audio recordings of nurses' comfort talk were labeled the Comfort-Talk Register (Morse & Proctor, 1998; Proctor et al., 1996) and were subjected to a linguistic analysis to explore the nature of comfort talk in more depth. Nurses' comfort talk was found to serve the following four pragmatic functions: (a) holding on or assisting patient endurance, which consists of praising, tolerating, supporting, commanding, guiding, and using distracting phrases or statements; (b) assessing the patient's condition, which consists of getting information, explaining, and validating; (c) informing the patient by warning and explaining procedures; and

(d) verbally communicating a sense of caring to the patient, which consists of making reassuring, empathetic, and caring statements (Morse & Proctor, 1998; Proctor et al., 1996). Although patient endurance, which allows efficacious and safe emergency care to be provided, has been clearly identified as the dominant positive patient outcome of nurses' comfort strategies, others mentioned include feeling safe, in good hands, in control, and more relaxed (Morse, 1992).

Hawley (2000b) also explored nurse comforting in the ER setting. Hawley interviewed patients who were treated in the ER about their perceptions of nurse comforting strategies. Five categories of comforting strategies emerged: immediate and competent technical/physical care, positive talk, vigilance, attending to pain and other physical discomforts, and including and attending to family. Within the category of positive talk, four types of talk were described: reassuring talk, coaching talk, explanatory talk, and empathic talk. As well, patients described the use of touch—for example, holding a hand or stroking the back or an arm—as comforting. In terms of positive outcomes, patients reported feeling safe, secure, less anxious, more relaxed, under control, confident, not alone, and able to cope with the unknown and with the pain. The patients in Hawley's study recalled nurse comforting strategies that were comparable to the comforting strategies identified in Morse's (1992) observational study of nurses providing comfort.

Given that the above studies explored the provision of comfort by nurses in the ER setting, the findings may not be equally applicable to nurses in the critical care setting. Similarly, Bottorff et al.'s (1995) description of comforting strategies used by nurses who care for patients with cancer may not adequately represent those strategies required to provide comfort to critically ill patients. Despite this tentative conclusion, however, this work is to some extent relevant and merits inclusion here. Bottorff et al. analyzed videotaped recordings using techniques of qualitative ethology. Comforting strategies that nurses were observed using to help patients endure the discomforts associated with their illness, treatment, or both included using gentle humor, offering physical comfort measures, making emotionally supportive statements, using comforting and connecting touch, increasing physical proximity, providing patients with information, supporting patients' active participation in decision making, and offering patients opportunities to engage in social exchange.

Walters (1994) explored the provision of comfort in the critical care setting. Following a thematic analysis of interviews conducted with expert critical care nurses, the themes identified included comforting the patient, providing relief from pain and anxiety, communicating, touching, comforting when death is imminent, comforting family and friends, and comforting other nursing staff. As in the studies reviewed above, Walters also identified the comforting strategies of touch, talking, and listening, with specific reference to the fact that expert nurses continue to touch and talk to heavily sedated and unconscious patients. Expert nurses were perceived to be strongly committed to helping their patients and to possess a remarkable ability to establish presence. The required ability of expert nurses to recognize the subtle cues of discomfort (e.g., changing vital signs, restlessness), particularly in those patients who could not verbalize their discomforts, was stressed. These expert nurses considered experience and knowing and understanding the patient to be vital to achieving an accurate assessment of discomfort in the critically ill patient. Expert nurses viewed meeting basic physical needs such as hygiene and grooming as an important aspect of providing comfort. In the case of dying patients, expert nurses considered managing pain, discontinuing unnecessary treatments, removing unnecessary equipment, and allowing family members as much time as possible with the patient to be appropriate and important comfort strategies. Expert nurses were also aware that a source of discomfort for families was seeing their loved one in a state of discomfort, and they recognized that their efforts to comfort patients were also indirectly comforting to family members.

A Sketch of the Horizon

> "Scientific knowledge as well as everyday knowledge believes that it has already had much to say about a phenomenon . . . before it has actually come to an understanding [of the meaning of the phenomenon]" (van Manen, 1997b, p. 47).

Through exploring the link between nursing science and nursing art, various definitions of nursing art, and the major findings of formal inquiry, it can be concluded that each of these areas has in some way contributed to furthering an understanding of the nature of the art of nursing. Although many of the formal inquiries reviewed did not use the term "nursing art" or "art of nursing", I have shown that their subject matter, whether it was excellence, expertise, caring, or comforting in nursing practice, is indeed relevant to the art of nursing. As a whole, however, an examination of this body of literature revealed that current knowledge about the art of nursing is predominantly at the descriptive level and therefore limits the depth of our understanding of the nature of the art of nursing.

In the literature there was frequent reference to the notion of nursing presence or being there; the establishment of a connection between the nurse and the patient; the effective use of touch, talking, silence, and listening; the importance of "knowing" the patient and understanding the patient's experience; nurses' competence and skilled performance; compassion; support; respect for patients' uniqueness, dignity, autonomy, and worth; and nurses' ability to empower patients and to comfort. Yet what is missing in the description of many of these dimensions is their contextual lived meaning. What is the nature or lived meaning of touch, presence, comforting, silence, connecting, support, empowerment, and so forth? As well, patient outcomes were described in terms such as feeling safe or being "in good hands," feeling valued and important, enhancing trust, inspiring hope and courage, finding meaning in their experiences, and being made comfortable. But again, the contextual lived meaning of these positive outcomes remains poorly understood. What does it mean in the context of lived experience to feel safe, to feel valued or important, to have hope, to have courage, to trust, to be comfortable? In approaching this inquiry into the lived experience of making a difference in critical care nursing practice, I assumed that dimensions such as touch, connecting, presence, support, comfort, hope, and trust would be uncovered as well. However, the significance of this inquiry is that, in this interpretive-descriptive analysis, the contextual lived meanings were revealed and the nuances of the experience were brought to light (Cameron, 1998).

CHAPTER 3

METHOD

> All my knowledge of the world, even my scientific knowledge, is gained from my particular point of view, or from some experience of the world without which the symbols of science would be meaningless. The whole universe of science is built upon the world as directly experienced, and if we want to subject science itself to rigorous scrutiny and arrive at a precise assessment of its meaning and scope, we must begin by reawakening the basic experience of the world of which science is the second-order expression. (Merleau-Ponty, 1962, p. viii)

Hermeneutic Phenomenological Inquiry

Hermeneutic phenomenology was the approach that I took in this inquiry to describe and interpret the experience of making a difference in critical care nursing practice from the perspectives of those who have lived the experience. I used the methodological approach, which van Manen (1997b) outlined.

Hermeneutic phenomenology is an approach to inquiry that lies within the tradition of human science and employs the methods of phenomenology and hermeneutics. In being attentive to both methods, this approach is both descriptive and interpretive in nature. It is "the study of the lifeworld (*Lebenswelt*)—the world as we immediately experience it pre-reflectively, rather than as we conceptualize, categorize, or reflect on it" (van Manen, 1997b, p. 9). The distinguishing feature of hermeneutic phenomenology is its aim of gaining a deeper "understanding" (*Verstehen*) of the nature or meaning of our everyday lived experiences (van Manen, 1997b).

Hermeneutic phenomenology seeks to know (understand) what a particular experience is like (van Manen, 1997b). Rather than striving for theoretical explanation, prediction, and control of phenomena, hermeneutic phenomenology aims for an understanding that makes human experience more meaningful. As van Manen explained, hermeneutic phenomenology "offers us the possibility of plausible insights that bring us in more direct contact with the world" (p. 9).

Hermeneutic phenomenology seeks to grasp or intuit the "meaning" of lived experience. Thus, it requires that the investigator return to the prereflective world in which people already live before they develop knowledge about it. Merleau-Ponty (1962) argued that it requires that the investigator "return to things themselves" (*Zu den Sachen*), to return to the world as lived:

> that world which precedes knowledge, of which knowledge always *speaks*, and in relation to which every scientific schematization is an abstraction and derivative sign-language, as is geography in relation to the country side in which we have learned beforehand what a forest, a prairie, or a river is. (p. ix)

Hermeneutic phenomenology aims to explicate meaning embedded in lived experience. However, because the meaning embedded in lived experience is multidimensional and multilayered, it can be communicated only textually (van Manen, 1997b). Thus the explication of meaning requires language in the form of text (van Manen, 1997b). Hermeneutic phenomenology, then, is a textual activity for the purpose of describing and interpreting lived experience with the goal of explicating meaning. As such, this approach to inquiry is fundamentally a writing activity in which the investigator engages in a process of hermeneutic phenomenological reflection. Through writing the investigator thoughtfully brings to speech a reflective understanding of some aspect of the lifeworld (van Manen, 1997b) in such a way that both the cognitive and noncognitive meanings are revealed (van Manen, 1997a, 1997b). Once this understanding is evoked, it is practically significant in that it ultimately fosters "one's thoughtfulness and practical resourcefulness or tact" (van Manen, 1997b, p. 4).

The methodological structure employed in this inquiry was a dynamic interplay among six research activities or themes (van Manen, 1997b, p. 30): (a) turning to a phenomenon that seriously interests us and commits us to the world, (b) investigating experience as it is lived rather than as it is conceptualized, (c) reflecting on the essential themes that characterize the phenomenon, (d) describing the phenomenon through the art of writing and rewriting, (e) maintaining a strong and oriented relation to the phenomenon, and (f) balancing the research context by considering the parts and the whole.

Commitment to Lived Experience

In this inquiry the lived experience of making a difference in critical care nursing practice was the phenomenon of interest. This experience of making a difference is one to which I, as well as other nurses, can relate. Yet the question of the meaning of this experience in the context of nursing practice remained. What is the experience of making a difference like? How do nurses make a difference? What difference do nurses make? As such, I took on the exploration of the experience of making a difference in the context of critical care nursing practice as a commitment, a personal endeavor.

In choosing a hermeneutic phenomenological approach for this inquiry, I made an obvious assumption: that what inheres in the experience of making a difference in the context of nursing practice is a lived experience. Although nurses may be consciously aware of having made a difference to a patient in their care, the "how" and "what" (i.e., the concreteness) of this experience is not brought into reflective awareness in the everyday practice of nursing. Benner et al. (1996) described this notion more clearly: "The everyday practice of nursing is an engaged practical activity in which nurses are fully and unreflectively involved in everyday action" (p. 352). Everyday nursing actions are predominantly carried out without deliberation or reflection. Accordingly, nursing activity is commonplace or taken for granted. Therefore, accessing engaged practical activity requires an interpretive approach to inquiry, a notion that was affirmed for me on the basis of some previous work (Hawley, 2000a). In other words, the meaning of the experience of making a difference can be understood only by reflecting on the experience as lived in the context in which it occurs.

In making a commitment in hermeneutic inquiry, I was also inherently committed to maintaining objectivity and subjectivity. Maintaining objectivity means that the investigator must remain oriented or faithful to the "object" of the inquiry (van Manen, 1997b, p. 20). Maintaining subjectivity means that the investigator must "be as perceptive, insightful, and discerning" as possible to "disclose the object in its full richness and in its greatest depth" (p. 20). Maintaining subjectivity also means that the investigator must be "strong in orientation to the object of the inquiry in a unique and personal way," yet "avoid the danger of becoming arbitrary, self-indulgent, or getting captivated and carried away by unreflected preconceptions" (p. 20), all which may sway the investigator toward a biased interpretation. van Manen believed that

> the problem is that our 'common sense' pre-understandings, our suppositions, assumptions, and the existing bodies of scientific knowledge, predispose us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological question. (p. 46)

However, as van Manen (1997b) asserted, "If we try to forget or ignore what we already 'know,' we may find that our presuppositions persistently creep back into our reflections" (p. 47). The solution to the problem of potential bias, then, does not lie in "bracketing," in the strict Husserlian sense of the term. Rather, it is better to make our understandings, beliefs, biases, assumptions, presuppositions, and theories explicit and, to the extent possible, come to terms with them so that, in turn, we can "hold them deliberately at bay" or "even turn this knowledge against itself, as it were, thereby exposing its shallow nature" (p. 47). Thus, to the extent that I achieved subjectivity, I recognized its strength; I was helped to maintain objectivity (i.e., I remained faithful in the interpretation of the lived experience).

Investigation of Lived Experience

Although lived experience is the object of hermeneutic phenomenology, it is also the source of the inquiry. In keeping with the tradition of hermeneutic phenomenology, I "collected" lived-experience material in its different forms, including my personal description of lived experience; etymological word sources (Onions, 1966); idiomatic phrases; lived-experience descriptions from conversations with participants and from the literature, poetry, story, and biography; and the hermeneutic phenomenological literature (van Manen, 1997b). By far, however, the majority of lived-experience descriptions originated in conversations with critical care nurses. Therefore, this aspect of the inquiry process warrants elaboration.

Participants. The lived experience of making a difference in critical care nursing practice was the phenomenon of interest in this inquiry. Given that I had to rely on critical care nurses to identify themselves as having had the experience of making a difference, the participants were a volunteer sample who were recruited into the inquiry on the basis that they could provide the information necessary to further the descriptive and interpretive aspects of the inquiry (Morse, 1991). As is typical in interpretive inquiry, the number of participants was guided by the data analysis itself. As I collected and analyzed the data, I identified new directions for the collection of data, revisited the current participants, and added new participants. A total of 16 critical care nurses participated and represented such critical care units as coronary care (CCU), cardiovascular intensive care (CVICU), neurosurgical intensive care (NSICU), general systems intensive care (GSICU), and the burn unit.

Recruitment. Critical care nurses were recruited from the University of Alberta Hospital and the Royal Alexandra Hospital. Initially, I contacted the Patient Care Directors of the adult critical care units in each of these hospitals to discuss the inquiry and obtain permission to arrange to meet with staff nurses in each of the critical care units. Recruitment sessions were held during coffee breaks on selected days to cover all shifts and rotations. I made an informal presentation and re-explained the nature and purpose of the inquiry and the participants' expected level of involvement (Appendix A). As well, I posted notices (Appendix B) in several prime locations on each of the units to ensure that I also reached nurses who were unable to attend the recruitment sessions.

All of the potential participants who contacted me to express an interest in participating met the following criteria for inclusion in the study: (a) a critical care nurse currently employed in a staff nurse position, (b) one or more experiences of making a difference, (c) ability to clearly articulate detailed experiential information, (d) willingness to participate and agree to repeated conversations, (e) willingness to discuss and participate in the emerging interpretation, and (f) willingness to participate in a final validation of the findings.

Once I determined that a critical care nurse had met the inclusion criteria, we arranged a mutually convenient time and place for the initial "conversation," which took place in a private, quiet setting of the participant's choice (e.g., my office, the participant's home, or a room within the institution, but away from the unit). At the beginning of the initial meeting, I explained the study again and obtained written informed consent (Appendices A and C). I then gave each participant a copy of the information sheet and the signed consent form. Once I had written consent, I engaged in general conversation with each participant with the intent of establishing rapport and building trust. Once the participant and I were ready to begin the conversation, audiotape recording began.

Conversations. I chose the term conversation rather than interview to more fully describe the actual process of data collection that I used in this inquiry (Bergum, 1991). Conversation implies a discussion or dialogue and best reflects the type of interaction involved (Bergum, 1991). Gadamer (1989) described conversation as a "process of coming to an understanding" (p. 385). "To conduct a conversation means to allow oneself to be conducted by the subject matter to which the partners in the dialogue are oriented" (p. 367). What needs to be grasped is not the particular individual, but what the other says, his or her point of view (Gadamer, 1989). Therefore I remained open to the other and was accepting of the other's point of view.

In hermeneutic phenomenology the data-collection and data-analysis phases of the inquiry process are seen as part of the same process (van Manen, 1997b). However, for clarity, a distinction between these phases will be made herein, and each of these aspects of the inquiry process will be discussed separately. The notion of conversation connotes two different types, depending on the focus and stage of the research process. However, for all intents and purposes, both types of conversations are addressed here. In the initial phase of the inquiry process the conversations focused primarily on gathering lived experience material in the form of anecdotes or stories in which the participants recollected the lived experience. Later in the inquiry process repeated conversations became increasingly more hermeneutic as the participant and I dialogued and reflected on the evolving analysis and interpretive description (van Manen, 1997b).

In the course of the initial conversation I asked the participants to recall and describe an experience(s) that they believed had made a difference in their practice and to recapture this experience in such a way that the meaningful aspects could be recognized or uncovered. The participants provided rich and concrete descriptions that stayed close to the experience as lived by relating their experiences narratively in the form of stories or anecdotes and including their thoughts, perceptions, feelings, and emotions. I encouraged them to describe their experience as fully as possible without making suggestions for responses. Additional questions flowed within a clue-and-cue-taking process to probe for clarification, elaboration, and deeper meaning of the experience (Ray, 1994). When concreteness or specificity began to dissipate, I interjected with questions such as the following: "Can you give me an example?" "What was it like?" "What were you feeling?" "What were you thinking?" At the end of the initial conversation I obtained biographical data from the participants for the purpose of later describing the sample (Appendices D and E). I then negotiated future conversations with the participants as needed.

All conversations were audiotaped and later transcribed into textual data by a transcriptionist, and I assigned each participant a pseudonym. Immediately following each conversation, I listened to the audiotaped recording and recorded field notes, if applicable, on my observations and reflections on the conversations in a reflective journal to later facilitate my understanding of the context in which the conversations took place (Morse & Field, 1995). Once each conversation was transcribed, the audiotape was replayed and the transcript checked for accuracy.

Reflection on Lived Experience

I used a process of hermeneutic phenomenological reflection to gain insight into the structure of meaning of the lived experience of making a difference in critical care nursing practice. Initially, the analysis involved a thematic analysis—a reflective process by which the structures of meaning of the experience or themes were determined. In turn, these themes became the threads around which I wrote the reflective text. That is, the themes provided a focal point to facilitate the hermeneutic phenomenological textual description. As van Manen (1997b) recommended, I used three approaches to derive the themes: the sententious or holistic approach, the selective or highlighting approach, and the detailed, line-by-line approach (pp. 92-93). In short, I uncovered thematic aspects of the lived experience by examining words, phrases, sentences, textual excerpts, and each transcript as a whole.

Once I had isolated the themes, I creatively and reflectively transformed them into "more phenomenologically sensitive paragraphs" (van Manen, 1997b, p. 95). In this reflective process, I used the lifeworld existentials of spatiality (lived space), corporeality (lived body), temporality (lived time), and relationality (lived relationship to others) as guides (p. 101). Within this process, I also wove other sources of lived experience material into the developing reflective text. In structuring the text, I used the technique of "varying the examples" to demonstrate the "invariant" aspects of the phenomenon as it came into view (p. 121). The aim of the thematic analysis and reflective process was to create "a more full-fledged phenomenological textual description," an interpretive-descriptive text that would be rich and deep in meaning (p. 106).

In a journal I recorded my observations and reflections on the conversations with the participants. I also included as part of this journal my reflections on various readings, personal experiences, the evolving interpretive analysis, and so on, as well as an audit trail of the interpretive decisions (Drew, 1989; Rodgers & Cowles, 1993).

Writing and Rewriting Lived Experience

As I indicated earlier, hermeneutic phenomenological inquiry is primarily a writing activity. To creatively write a text that captured the meaning of lived experience in all its dimensions and layers, I engaged in various levels of questioning and sought further and deeper reflection. To create this depth and breadth of meaning, I not only wrote, but also rewrote; not only reflected, but also re-flected. I engaged in a conversational relationship with the text as well as with the participants and was attentive to what was said and what was left unsaid (Bergum, 1991). In other words, I was "sensitively attentive to the silence around the words" (van Manen, 1997b, p. 131) in attempting to disclose the deep meaning of the experience. In short, it was only in the rewriting (and re-flecting) that I was "able to do justice to the fullness and ambiguity" (p. 131) of the lived experience of making a difference in critical care nursing practice. Perhaps it is these words of van Manen that best capture the complexity of what was involved in the writing and rewriting process:

> The process of writing and rewriting (including revising or editing) is more reminiscent of the artistic activity of creating an art object that has to be approached again and again, now here and there, going back and forth between

> the parts and whole in order to arrive at a finely crafted piece that often reflects the personal "signature" of the author. (pp. 131-132)

Ethical Considerations

I received ethical clearance to conduct this inquiry from the Health Research Ethics Board, Capital Health Authority. Although I provided potential participants with information on the nature and purpose of the inquiry during the recruitment phase, I re-explained it to all of the participants prior to signing the consent (Appendices A and C). I assessed all of the written information, including the recruitment notice (Appendix B), for readability using the Flesh-Kincaid Grade Level Score, which showed that it was at an eighth-grade reading level. I advised the participants about the likelihood of having several ongoing conversations in which they would be active participants in the interpretive process, including a validation of the interpretive-descriptive text that evolved and offered them an opportunity to address any concerns or questions that they might have had. I then gave each participant a copy of the information sheet, which included my contact number, and the written consent. Each conversation took place at a mutually agreed upon time, and the setting for the conversation was the participant's choice. I informed them that I expected each conversation to last approximately one hour and that I would audiotape the conversations.

I then assured the participants that their names would not be audiotaped, but that I would assign them a code name (pseudonym) that would appear on the transcripts of their conversations. I informed them that, for the purpose of later describing the sample (Appendices D and E), I would ask them for their biographical data (e.g., age, sex, marital status, years of critical care nursing experience, total years of nursing experience, specific critical care unit in which they were employed, level of nursing education attained, and employment status). I also informed them that (a) I needed a contact phone number(s) to arrange later conversations; (b) I would keep all personal information confidential unless professional codes of ethics or legislation required reporting; (c) the tape recordings would be kept separate from any information that might identify the participants—consent forms, field notes, tapes, and transcripts—in a locked cabinet in my residence; (d) if I further analyze the information from this inquiry in future years, I will obtain ethical clearance prior to its use; and (e) I will keep the data secure for a period of seven years and then destroy it.

I also informed the participants that someone other than myself might transcribe their conversations and that my supervisory committee would have access to the transcripts for the purpose of providing guidance throughout the reflective analysis and writing phases of the inquiry. However, no names would be audiotaped, and only code names would appear on the transcripts. I informed them that excerpts or quotations from their conversations might be included in the final text for the purpose of providing examples or enriching the text, but that, in the event that names were associated with this information, I would use only pseudonyms. In addition, I informed them that the findings of the inquiry may be published, presented at conferences, or both; but again, only pseudonyms would be used in either format of presentation. I offered the participants a complimentary copy of the final text.

It should also be noted here that I advised the participants at the beginning of the interview not to reveal the identity (i.e., the names) of their patients as they told their stories. However, as the stories were gleaned from the data, I decided to assign fictitious names to the patients in the stories with the intent of enhancing the reality or the "life" of the story as I transformed it into a written format.

I assured the participants that their participation in the inquiry was voluntary and that they could withdraw from it at any time by informing me. No reason would need to be given. No one but I would know about the decision, and there would be no adverse consequences. In the event of their withdrawal from the study, I would not use any information that I obtained, but would destroy it.

Throughout the inquiry, the well-being of the participants took precedence over the inquiry and my goals. I informed them that participation in this inquiry would involve recalling and perhaps reliving meaningful, intimate moments from their nursing practice that, subsequently, might evoke an emotional response. In the event that this type of response did occur, I was prepared to allow sufficient time to talk with or debrief the participants about these various meaningful incidents. On a few occasions they (and I!) shed tears during the storytelling. However, there was no cause for concern, and after a brief period of silence, sharing, or a combination, the participants resumed the conversation feeling fortified. Although issues beyond the scope of the study did not arise, I was prepared to engage in a discussion about available resources to offer more appropriate assistance to the participant. Although there were no expected overt benefits from participation in this inquiry, I anticipated that some participants might find it beneficial to have the opportunity to tell their stories about making a difference in the context of their nursing practice. Indeed, in retrospect, several critical care nurses commented that their participation in the inquiry, particularly the chance to tell their stories about making a difference, provided them with an opportunity to reflect on their work with patients and, ultimately, affirmed their choice of nursing as a career. One nurse commented that because of her involvement in the inquiry, she had acquired a whole new perspective on her work, one that she found exhilarating. Another stated that having the opportunity to just talk with someone who shared her love of nursing left her feeling "*on top of the world.*"[1]

Evaluative Criteria

The standards by which hermeneutic phenomenological inquiry is evaluated go beyond the issue of textual validity in the narrow sense of the term and therefore also include an evaluation of the extent to which the interpretive-descriptive text reflects the aesthetic spirit of qualitative inquiry (Sandelowski, 1993, 1995; van Manen, 1997b). In other words, the notion of "rigor" has been softened to include "the playfulness, soulfulness, imagination, and technique that is associated with more artistic endeavors" (Sandelowski, 1993, p. 8).

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[1] Italics are used throughout the body text to signify the actual words, phrases, excerpts, or anecdotes of the participants.

In recognizing that the validity of the interpretive description is dependent on the investigator's ability to elicit the meaningful aspects of the lived experience from participants during conversations, I submitted the audiotapes of the first three initial conversations to my supervisor for critique and made recommended revisions to leading statements or my questioning technique as necessary. In considering that the evolving interpretation was an intersubjective process, the active involvement of participants in the evolving interpretation also provided a means to enhance validity.

In writing the interpretive-descriptive text, I attempted to creatively capture the meaning of the lived experience of making a difference in critical care nursing practice in a way that was "both holistic and analytical, evocative and precise, unique and universal, powerful and sensitive" (van Manen, 1997b, p. 39). I aimed to construct an interpretive-descriptive text that was oriented, strong, rich, and deep (pp. 151-153) and endeavored to maintain a strong orientation to the phenomenon (p. 33) by making a disciplined effort to be attentively aware of all assumptions and pre-understandings regarding this lived experience throughout all phases of the inquiry.

I was as "perceptive, insightful, and discerning" as possible "in order to show or disclose the lived experience in its full richness and in its greatest depth" (van Manen, 1997b, p. 20). I also endeavored to create vivid text by using concrete description, examples, quotations, anecdotes, metaphors, and so on, and by incorporating other relevant lived experience material such as that found in literary sources and in the phenomenological works of others.

According to van Manen (1997b), an interpretive-descriptive text is considered to be valid when it provides an "adequate explication of some aspect of the lifeworld—

it resonates with our sense of lived life" (p. 27). "It is something that others can nod to, recognizing it as an experience that one has had or could have had" (p. 27). In other words, interpretive description "is collected by lived experience and recollects lived experience—is validated by lived experience and it validates lived experience" (p. 27). The extent to which the interpretive description of making a difference in critical care nursing practice was judged as valid ultimately resided in its power to evoke recognition of the experience among the participants. Therefore, I considered the validity of the interpretive description achieved when, after discussing the evolving text that interpretively described the lived experience of making a difference in critical care nursing practice, the participants responded with statements such as "*Yes, that's it. You've really captured it.*"

CHAPTER 4

THE WORLD OF CRITICAL CARE NURSING PRACTICE

> "Wherever the sickest or most helpless happen to be, there I held my watch" (Louisa May Alcott, 1863, p. 47).

A Spatial Gathering of the Sickest

Since their inception in the 1950s, critical care units have occupied a space in most hospitals. They constitute a place where the critically ill are gathered. Although many may believe that the emergence of critical care units represented a novel approach to the care of the critically ill, their development was, in fact, actively influenced by traditional practices of nursing; namely, intensive observation or "watchful vigilance" and patient triage, the sorting, grouping, and spatial arrangement of patients according to their physiologic stability (Fairman, 1992). Dating back to the "late nineteenth-century hospitals, nurses gathered their most unstable and critically ill patients closer to their vantage points where they could easily watch for critical changes in condition" (p. 56).

Over time, critical care units have become increasingly more technologically sophisticated and ever demanding of new and more knowledge, skill, and technological expertise. The "technological imperative" (Drought & Liaschenko, 1995, p. 298) reigns within these spaces. As the words of Tisdale (1986a) so aptly describe it, "We can; therefore we do" (p. 430). Yet despite the infusion of technology-supported care into these spaces, nursing's presence continues to dwell in the critical care units of today (Fairman, 1992).

The Battle

Within the space of the contemporary critical care unit, the ultimate battle of modern health care is fought. Herein the quest to defeat death, the enemy, is compelling and the fight against disease or injury ever commanding.

Physicians and nurses are amongst the brigade of warriors dedicated to fight this battle. Although their contributions to this war effort are distinct, they are also complementary in nature. The traditional chain of command, with the "chief-of-staff" as the highest commander, helps to maintain order. But as commands flow downward, one is quick to realize that, without a collaborative effort among the ranks, the battle can quickly get out of order.

As the victims of life-threatening disease or injury, the critically ill are necessarily held captive as this battle is fought. In addition, as the targets of attack on the enemy, the wounds and insults they sustain during the course of the battle victimize them even further. Yet despite their weakened and vulnerable state, these critically ill captives partake in their own struggles to overcome death. As the innocent victims of critical illness, they rage their own internal battles against the ravages of disease or injury that threatens their lives. Perhaps, then, they too are warriors—and perhaps, given their plight, the most courageous warriors of all.

Triumphs and defeats reside in this place of battle. Dramatic efforts to conquer death, disease, or injury have resulted in remarkable successes. A "*good save*" is a source of warrior pride. Yet defeats still cohabit in this space. Death, often amidst heroic measures, lingers still. And despite attempts to impede them, the devastating effects of disease or injury continue to manifest. As the battle against the enemy persists and the boundaries of technology are advanced, increased risk of harm and human cost seeps into this space. Ethical and moral dilemmas too have come to reside in the terrain of this place of battle. Furthermore, with them have come perplexing questions about the nature of triumphs and defeats. Must death be known only as an enemy? Or can it also be known as a "kind rescuer" (Heron, 1987, p. 238)? Can the death of a critically ill patient, "*sent home*" in comfort and with dignity respected after a battle well fought, be considered a triumph rather than a defeat? Is it really a triumph when, after saving a critically ill patient's life, this life remains unliveable, that he or she is unable to "live" life, unable to be engaged in the particularities of life, unable to "have a life" (Drought & Liaschenko, 1995, p. 301)?

In the eyes of the critically ill, the battleground of the critical care unit is a foreign space, a place where little comfort can be taken from the familiar (Cooper, 1993). When one is in home territory, its familiarity is a source of comfort; one feels "at home" and that one "belongs" in this place. However, in the daunting and alien environment of the critical care unit, the critically ill may no longer feel "at home," but rather "out of place" (Paterson & Zderad, 1976). Rather than feeling the comfort of belonging, the critically ill may feel the discomfort of not belonging. Yet is it not ironic that, given the nature of their predicaments, the critically ill do belong here—that their captivity in this place of battle is the "rightful place" for them to be? As one dares to take a closer look at and in this place of battle, perhaps its rather paradoxical nature may be even further revealed.

The Battleground

Critical care units in most hospitals today are architecturally distinct and architecturally discrete spaces (Fairman, 1992). In addition, they also tend to be geographically isolated spaces—set apart, remote, out of the way, off the beaten track. Could this be a spatial expression of their symbolic position (Abram, 1997)?

Once there, one discovers immense double doors—fortress doors—that remain closed. Unauthorized admission denied. Requests by family and others to enter must be called in by phone. Hovering outside, these occasional intruders await permitted entry. Do such spatial barriers contribute to a heightened sense of the intrigue and mystery that already surrounds these spaces? As the minutes spent waiting crawl by, does one wonder what lies behind closed doors?

Inside these doors is a foyer and yet another set of double doors. Signs above huge sinks that lie off to the side command anyone entering these doors to first wash their hands—a ritual act to ensure that foreign invaders are left behind. The critically ill, held captive inside—on the other side—are a vulnerable lot. They must be protected from further assault. Yet is this ritual act perhaps not also a rite of passage for all who enter, a symbolic act of preparation to enter a different world?

As one passes through the fortress doors, one confronts the bright lights, the "perpetual day" lights, which illuminate the technology that looms in this fast-paced, highly charged place. As the doors close behind those who enter, one is reminded of the enclosed space. Yet is it not also a space that is wide open to the unexpected?

Mechanical ventilators, oxygen and suctioning equipment, intra-aortic balloon pumps, temporary pacemakers, chest tube drainage systems, and dialysis machines, to mention a few, are all part of the armamentarium deployed here. Probes, cardiac monitors, oxygen saturation monitors, arterial pressure monitors, pulmonary artery pressure [PAP] monitors, and intracranial pressure [ICP] monitors—technological extensions of the senses—provide information about the clinical status of the critically ill. Parameters are defined; data are gathered (Tisdale, 1986b). Critical indicators of bodily function accumulate, their numbers used to legitimate. Vasoactive drugs, blood and blood products, total parental nutrition [TPN], and fluids with electrolytes or vitamins flow like sap from trees of intravenous [IV] fluid pumps. Invasive surgery, potent antibiotics, and cytotoxic therapy—all are weapons used in the pursuit of the enemy.

Inside this high-tech battle zone one hears a cacophony of unnatural and alarming sounds—beeps, buzzes, hisses, gurgles, hums, and whooshes, punctuated with blurting messages, hushed voices, and "lofty medicalese" (Schroeder, 1998, p. 15). From close range one may also hear the strangled cries of pain or the gasping sounds of "life and death changing places" (Heron, 1987, p. 238).

The Warriors

The Critically Ill

The critically ill are harbored in small, glass-enclosed rooms or in a large bay area. Behind barricades of monitors, they obscurely lie, dwarfed in the shadows of the technology. In high-tech beds, their imprisoned bodies lie flat—recumbent and listless—tethered to machines (Cooper, 1993). Lines going in; tubes coming out (Wolf & Langner, 2000). Many drift in and out of awareness, lost in time. As their battles for life are being supported, their lived lives are suspended.

Whereas their bodies are scantily clad, their inflicted wounds are fully dressed. Yet despite the camouflage, their suffering is still hard to disguise, for they wear it on their faces—in the guise of fear, worry, pain, confusion, fatigue, or grief. In surrendering their own clothing they shed pieces of their identity and expose themselves to violation. In terms of their formation, no attempt is made to keep genders distinct (Cooper, 1993). Any attempt to respect privacy often seems all but extinct. Males and females may lie side by side, and even behind a drawn curtain, no one can ever totally hide.

Now far from home, experiencing their world in unfamiliar ways, the critically ill no longer have the same control. Rather than controlling their own world, long-established practices and policies serve to control them (Wolf & Langner, 2000). Now critically ill, their bodies are beyond control, responding in unusual or unexpected ways (Morse et al., 1995). Previously obedient bodies are now disobedient. Previously reliable bodies are now unreliable. In the captivity of critical illness, the critically ill are no longer self-reliant, but rather reliant on others. The command of life they once cherished has now been seized, and as they teeter on life's edge (Wolf & Langner, 2000), they are dependent on others for their living and dying (Cameron, 1998). Control of their lives has now been taken into the hands of those other warriors (physicians and nurses) who cohabit in this space. For these other warriors, taking control is not out of place. After all, isn't this space, for them, just commonplace (Paterson & Zderad, 1976)?

The Physicians

As the highest ranking commander, the intensivist or chief-of-staff, commissioned to oversee the administrative aspects of the critical care unit, ensures that all is kept in order. Unless summoned to the front to settle a high priority matter, the amount of time that the chief-of-staff actually spends on the battlefield is relatively limited. Moreover, unless planned ahead, the chief's time of arrival is usually unpredictable. Aside from conducting periodic inspections to get the "lay of the land" or the need to issue a command, the chief-of-staff is otherwise occupied back at the base with the ongoing charge to overall strategize.

On the other hand, the lower ranking physicians, the residents, are more directly involved in the ongoing battle. For resident physicians, the actual day-to-day battle and its associated decision making are in their command, and it is essential that they keep themselves and others well informed. They spend more time on the battleground, and even when they are "on leave," they remain in fairly close proximity so that they can be quickly summoned for help in time of crisis or need.

At least once daily, at a relatively predictable time, an entourage of staff—physicians, residents, respiratory therapists, dieticians, and so on—parade through the front lines to conduct their "rounds," and most days the nurse in charge of the unit can be seen taking up the rear. Each of the critically ill is discussed in turn as the group huddles around the chart at the bedside. The nurse in charge of the patient presents an updated report on the patient's status that may include such information as numerical data, responses to treatments, recent changes, and present concerns. Often attached to the report are requests for changes in orders, reorders, or new orders. In turn the physicians and other members of the entourage may seek further clarification by asking the nurse specific questions about the patient, or they may proceed directly to the patient to conduct their own assessment. Once all of the data have been considered and the tactics deliberated, the physicians issue their commands in writing, and the parade moves onward to the next patient. The nurses awaiting their arrival stand at their patients' bedsides. As the critically ill wait, one wonders whether the exposure of their bodies during the upcoming inspection will leave them feeling as if they too have been on parade.

The Nurses

Critical care nurses are stationed at the bedside—on the front line, the scene of the battle. Once the parade of "rounds" has disbanded, these front-line warriors are left behind to implement the issued commands. Dressed in their protective armor—scrubs, gowns, gloves, masks, goggles—with their instruments, their bodily extensions, attached—stethoscopes, scissors, hemostats, penlights—they join their critically ill patients to carry on the fight.

Given their "position," these critical care nurses are the "hub of communication" (Schweitzer, 1994, p. 55). As the "interpreters of all languages" (p. 55), they are both key informants and special agents of intelligence. They are ever "on guard" in shifts around the clock—seven days a week, 365 days a year. They are constantly vigilant and conditioned to quickly respond to the sound of an alarm, the signs of distress, or the smell of danger (Schweitzer, 1994). So too they continually attempt to guard their critically ill against intrusion. Thus they also are keepers of the fortress gate and do all within their power to ensure that the efforts of all coordinate.

When one critical care nurse is overwhelmed with the crisis of an unstable patient or a "code," a battalion of helpful comrades suddenly descends on the scene.

With a calm steadiness, they move swiftly and deftly to help reestablish order and control. Then gradually, one by one, they retreat to their own stations, back to the bedside to resume combat with their own patients.

Many critical care nurses are now veteran nurses, and over the years they have earned their stripes. Because of their knowledge and skill, they are considered the elite among nurses, and therefore they unofficially hold enormous power compared to that of nurses in other places (Fairman, 1992). When they enlisted they sought challenge, excitement, autonomy, advanced knowledge, and a higher degree of technical skill; and over time they have not lost sight of their initial vision. As veterans today, they are confident in their abilities, yet aware of their limitations. They are, on the whole, a cohesive and hardy regiment who generally conform to an implicit code of behavior and share a common set of beliefs and values. They can be trusted to "keep a close eye out" for those they trust and to "keep a close eye on" those who have yet to earn their trust. They put the new recruits through their paces and willingly show them the ropes.

Critical care nurses thrive on pressure and enjoy the *"adrenaline rush"* (Knepfer, 1989). But life in the trenches breeds its share of tension—the tension of doing battle, the tension of having to inflict pain, the tension of bearing witness to suffering, the tension of the unknown and the unpredictable, the tension of an "*unlimited job description,*" the tension of time constraints, the tension of dealing with others' emotions, the tension of dealing with family, the tension among the ranks, the tension of bureaucracy, the tension of trying to hide their own feelings and emotions, and at times the sheer intensity of their mission to enable patients to "have a life" (Liaschenko, 1995, p. 2), to "get on" with their lives (Drought & Liaschenko, 1995, p. 303), often leaves them feeling physically, mentally, and emotionally drained.

However, along with the exhaustion comes a sense of pride and satisfaction in knowing that, at the end of a day in combat, these nurses did their best, that they gave it their best shot. There is also the occasional external reward of recognition and appreciation from the critically ill themselves, their families, the nurses' comrades, or those in the upper ranks. With a sense of fulfillment and a period of rest, they will return another day. Fortified and with might, they are willing to continue the fight.

Drills and Protocols

The day-to-day battle of the nurses in the trenches of the critical care unit is embedded in routine procedures, ritualized tasks, and established protocols. And once nurses become familiar with them, they provide some sense of control, stability, and predictability to what can be an out-of-control, unstable, and unpredictable place.

At the change of shift a tour of duty ends for some critical care nurses and begins for others. In pairs, the nurses huddle at a desk or over a bed-table near the bedside for the ritual changing of the guard. As they peer through the chart, the nurse going off duty gives a verbal report on the patient's history and current status, as well as other objective information that will be pertinent to the conduct of battle during the upcoming tour of duty. Key assessment findings, medications, laboratory values, IV fluids and flow rates, ventilator settings, other important parameters, tasks completed, tasks left undone, recent test results, and tests or procedures planned are among the important pieces of information included. As the end of the report draws near, the reporting nurse's own judgments and comments on the patient are added to complete the report (Cameron, 1998). While attentively listening, the nurse receiving the report records any information and personal reminders that will be pertinent throughout the tour of duty—information to be communicated at rounds, orders to be requested, data to be gathered, tasks to be completed, upcoming tests and procedures to be planned, points to be clarified, situations to be investigated, and concerns to be addressed. As the report is given, one nurse is briefed while another is debriefed. As one nurse prepares to take up the battle, another nurse prepares to take leave of the battle.

Immediately following the change-of-shift report, the oncoming nurses review their orders and conduct their own assessments of their patients and the equipment. In conjunction with a "head-to-toe" assessment (although not always in that order), lines and tubes are examined and manipulated to ensure proper functioning. Electronic devices are zeroed and calibrated against a gold standard to ensure that the data they provide are valid (Stone, 1995).

As no change-of-shift report can ever surpass the historical authenticity of the battle as it is recorded on (and evidenced around) the bodies of the critically ill (Frank, 1991), this routine inspection by nurses provides them with the firsthand knowledge they need to get themselves organized—to establish their priorities and map, to the extent possible, their continuation of the battle. It also provides them with a baseline from which they can detect any obvious (or subtle) changes in their patient's status, be it improvement or deterioration. From this time onward, they carry out their orders with precision and on time because, in fighting this battle, there is little margin for error, and at no time do they want to lose ground.

During the course of the battle, the hours may seem to trip over one another as they follow protocols and carry out a host of procedures and tasks, or drills. At least every hour, and sometimes several times an hour, nurses measure various pressures (e.g., blood pressure, central venous pressure [CVP], PAP, ICP); note heart rate, heart rhythm, and oxygen saturation; count respiratory rate; calculate intake and output, cardiac output, and cerebral perfusion pressure; test level of consciousness and spinal cord function; and finally, record and interpret the data and, if necessary, decisively act on the data.

At scheduled times, or on a PRN ["as needed"] basis, they administer carefully calculated doses of medications by a variety of routes. As required, they call for information, schedule tests, insert and tend to IV lines, remove tubes and drains, fill enteral feeding bags, assist with medical procedures, run dialysis, draw blood, collect specimens, suction endotracheal [ET] tubes, and organize transportation. According to protocol, they resuscitate and treat dysrhythmias. Guided by patients' responses

(Benner et al., 1999), they titrate medications and fluids and wean mechanical ventilation. On an ongoing basis they record data, identify trends, inform physicians, update charge nurses, speak with family, and consult with other health care professionals. When they find the opportune time, they provide body care (Lawler, 1993)—they care for the bodies of the critically ill. They bathe, they turn, and they mobilize. As part and parcel of their body care, they also change linens and cleanse and dress wounds. Finally, as the end of the shift draws near, they empty drainage, tally their "totals," tidy up their work spaces, restock supplies, record last-minute details, and prepare their end-of-shift report. As time marches on, a tour of duty soon ends for some critical care nurses and begins for others. And so the battle lives on.

The present-day critical care unit has become the high-tech battleground of modern health care. It is here, in the critical care unit, where physicians, nurses, and the critically ill join forces to defeat death, the enemy, and to fight disease or injury. Herein, some battles are won and some are lost.

As the victims of life-threatening disease or injury, the critically ill are a vulnerable lot who become even further victimized as this battle is fought. By virtue of their necessary captivity on this battleground, they find themselves in an unfamiliar and frightening place with little self-control and little privacy and, to some extent, stripped of their identity. Moreover, as the targets of attack on the enemy, they also suffer the additional wounds and insults inflicted on them during battle. Yet they remain courageous warriors.

The nurses are the frontline warriors who are stationed at the bedside in shifts around the clock. They maintain constant surveillance over the critically ill, are prepared to quickly respond to a crisis, and attempt to protect the critically ill from intrusion as they conduct their day-to-day battle in the trenches of the critical care unit.

CHAPTER 5

GETTING THROUGH THE BATTLE OF CRITICAL ILLNESS

> "Through our stories, the intangible can become tangible, and the artfulness of good nursing practice can be rescued from the margins" (Benner, 2000, p. 105).

I have described the critical care unit as a place where an ongoing battle against death, the enemy, is fought and where, around the clock, brigades of warriors continue to fight against life-threatening disease or injury. The prevailing notion of triumph as saving lives and death as defeat was evident. I portrayed a broad picture of the plight of the critically ill, depicted the crisis-like atmosphere of the setting, and provided a fairly detailed description of the day-to-day, ongoing, nursing care activities within the critical care unit. How well the battle is fought can make "the" difference between life and death. However, "how" the battle is fought can also make a difference in the lives of those it engages. In other words, as this battle is fought, it can also make a difference in the experience of those who "live" it. Triumphs of battle too? Perhaps. Given the purpose of this inquiry, the difference that nurses make in the lives of the critically ill who battle during this time of crisis will be elucidated. As intended, lived experience material in the form of anecdotes or stories about making a difference in critical care nursing practice constitutes a major portion of the data and thus constitutes the major lived-experience material available for reflective analysis. In this chapter, however, I offer these anecdotes or stories in their original form, "as told," not only as background for the interpretive-descriptive text to follow, but also for their inherent narrative value (Sandelowski, 1994).

Stories from the Trenches, Triumphs of the Battle

Ann Marie, a young woman in her mid 20s, was severely mentally challenged and totally unable to care for herself. She suffered from a rare disease that had caused severe life-threatening damage to her liver. Her only hope for survival was to have a *liver transplant. Given her situation, we [the nurses] were really opposed to her being put through the ordeal of a transplant. A transplant would also mean that she would have to be on anticoagulants for the rest of her life. How was her elderly mother, her primary caregiver, going to be able to care for her? That was a big concern for us too.*

They [the doctors] went ahead and did the transplant on her. They said they did an ethics consult. Well, she ended up having every complication in the book—every complication in the book! She was in our unit for about six months, and the transplant service refused to give up. It was as if her liver was to be saved at all cost, at the sacrifice of her. Yeah, her liver was still alive, but her body was dying. To me this was so morally and ethically wrong.

Her family were bewildered. They often sought comfort from the nurses.

But not all the nurses felt comfortable. Some of them were in a quandary over ethical questions like, "Do you tell them [the family] the truth?" "How much of the truth do you tell?" "Do you warn them of what's actually going on?" I think that's where my experience and confidence came in. I had also looked after Ann Marie a fair bit. I had developed a relationship with the family and felt comfortable expressing my personal opinion to them. I don't think I told them anything that they didn't already know deep down, but I think hearing it from me helped a lot, and they were able resolve a lot of issues. They were appalled at the doctors, just appalled.

In the end, I basically barricaded the door and said to the transplant service, "No! You no longer have any say over this patient, and we will give her some dignity and let her die." You know, not every critical care nurse can do that—and deal with the consequences of that and comfort the family. Eventually, our plea was heard and Ann Marie was allowed to die. After her death I got cards saying, "Thank you very much for being honest and truthful even though it could have jeopardized your position."

Mrs. Buckley was in her late 60s. She came from another city to have a liver transplant. Unfortunately, she went septic and had to be taken off the transplant list. She just got sicker and sicker. She soon got to the point where she was just too sick to *be transferred to a hospital back home. Her husband was here with her. He was such a dear man.*

I remember she was within a few hours of death and her husband was in the room. I gently wiped her face, combed her hair, repositioned her, and massaged her feet. I wanted to change her blankets, so I covered her with the new blanket first and then slipped the old one down from underneath it. It was such a small thing for a dying woman, but it obviously meant a lot to her husband. When I was all done, he turned to me and gratefully said, "Thank you so much for giving my wife her dignity."

Gordy was a truck driver in his early 50s. He had a real bad case of pancreatitis. They did surgery. Every complication under the sun set in. We had him in our unit for 11 months. We saw him through three or four cardiac arrests and six or seven different surgeries. He was trached and ventilated. We'd just get him weaned, and something else would go wrong. He'd be back to square one.

We finally got him totally weaned with no bugs in his system. We sent him to the floor, and two months later he was discharged. When we heard by e-mail from the floor's unit manger that he was going home, I thought, "Wow! Look what we did!"

I guess he was normally an introverted kind of guy; apparently estranged from his family. But during the course of events in the ICU, he became extremely withdrawn—he just closed himself off from people.

I was assigned to him on one of my stints. I was just doing my usual muttering away to myself, dropping things, spilling stuff on myself, falling over my feet. I would catch him looking at me with a real crooked grin on his face, and I'd think, "Oh boy, what have I done now?" And I'd just look at him and say something like, "Oh, I've done it again, haven't I?" He'd shake his head in agreement and roll his eyes. His grin was infectious. Just to see it made the stupid klutzy things I had done all worth it! I knew in my heart that I had made a difference.

I had had Mr. Brown as my patient quite a lot. He had had an ERCP [endoscopic retrograde cholangiopancreatography] and developed pancreatitis. I *always had hope that he would get out; he looked absolutely fine. When I was assigned to him, I always tried to decrease his sedation and try to get him going. He was on a KCI bed, and he wasn't getting any better. We bonded a lot. I said to him, "You know, you've got to get out of here."*

Then early one morning he unexpectedly started going into VT [ventricular tachycardia]. We started coding him, and we coded him and coded him to get him out of VT. And we defibrillated him, and the doctor said, "He's had a big infarct, and there's nothing we can do." And I said, "Well, you better call his wife."

His wife was called but didn't arrive till noon. In the meantime, we had defibrillated him three or four times, and he'd come back and be just wide awake. He was really sharp! When his wife finally arrived, the doctor wanted to speak to her in the lounge. I was hesitant because he could go into VT anytime. He was going to pass away in the next hour; I knew that from experience. So he's lying there in normal sinus rhythm, I'm holding his hand, and I said, "Your wife is here, and she's going to come and see you." He nodded. Then I said, "You're going to die today." I said, "I'm sorry, there's nothing we can do for you. You've had a bad heart attack, and you're gonna die." And he just nodded his head as I continued holding his hand. I call that hugs and kisses.

I asked him if he wanted to see the pastor. He said, "No." So I asked, "Should we pray? Let's say a prayer together. Do you mind?" And he goes, "No." So I held his hand, stroked his head, and said the "Our Father" loud enough for him to hear me. Just as the prayer was ending and as his wife was coming into the room, he went into VT and died. I was there with him. I said a prayer with him. I like to think that, in the end, I left him with a sense that there's some humanity here.

Mrs. White, an elderly lady, had extensive bowel surgery. She was just a bag of bones. When she came back from surgery she was very acidotic. Her condition continued to worsen. She got sicker and sicker. She came to us intubated but also ended up on Levophed and Dopamine. They [the surgeons] figured her bowel was necrotic.

But because she was so high risk, they didn't want to take her back to the OR. The doctors contacted the family, and when they all arrived, I was to turn the inotropes off.

We waited for her family to come, and they finally did arrive. They said that she wouldn't want to be intubated, so we extubated her. Then they all left. As I sat at the bedside with her, she started to get restless. She wasn't talking, but her eyes were still open. She looked up at me as if asking, "Where's my family?" She knew her family had been there, and I personally think that they should have stayed with her. For many reasons, sometimes because of a lot of quilt, families can't face up to the fact that someone is dying. That's been my experience with many a family.

While I do believe in keeping people comfortable, I don't believe in oversedating people for the simple reason that I think that, when you're dying, you should be as alert as you can be. But I did get some Versed and I gave her some. I stroked her head and I held her hand. I tried to explain to her that, even though her family wasn't there, I was there. At least she wasn't alone; I was there for her. Even if she was confused, she knew that somebody was there—that somebody cared enough to be there.

I had a patient, Phillip, a middle-aged man, who had just suffered his fifth heart attack. One day they attempted an angioplasty. It was unsuccessful. The doctors told him that he was going to need bypass surgery. That entire day he had been agitated, rude, and demanding to everyone, including his wife. As his oncoming night nurse, I was advised by the day nurse to only go into his room to get my stuff done. But I had other plans. I remembered being taught in nursing school that the most difficult patients are often the ones that are scared and lonely and nervous.

When I walked into his room that night with his pills I said, "Hi, I'm _______. I'm your nurse for the night. I know I'm a poor excuse for a Friday night date, but, unfortunately, you're stuck with me." He laughed at that point, but we had a good talk later. At one point he was in tears. He talked about his recent heart attack, his prognosis, and his planned surgery. He told me he was so terrified that he didn't know what to do. He said he felt that people were avoiding him and that he didn't have anyone to talk to. I explained some things to him, but mostly I sat and just listened, and *he was a lot more relaxed after that. He was very pleasant to me. He didn't complain when I asked him to get up or let me do his bloodwork. But the big thing was that he slept that night, the first time in days.*

John was a liver transplant patient in his late 50s or early 60s. I can't remember if it was before or after his transplant, but I do remember he was having a difficult time to relax and deal with everything that was going on. He was somewhat oxygen deprived, yet he wasn't ventilated. A relaxing technique that I tried with him was visualization. I calmly asked him to try and see if he could go far away from where he was right here, to go to a place, his favorite place, wherever that might be—a nice relaxing place with water or a forest, to go to some quiet place where he could just completely forget where he was with all the pain and the heavy work of trying to stay alive.

Whether it was that or just my voice, he started to relax. His breathing got easier. His heart rate went down. His blood pressure went down. Later I also gave him a foot massage, and he responded to that. Just working on relaxing him made the night go just so much easier for him, and he didn't have to be intubated.

Soon after, when I met his wife and daughters they just said, "Thank you for helping so much." Later when he was out of the ICU, they came by and asked me to come to see him. He was really doing well. It was then that he too thanked me for helping him get through. I was so surprised. I didn't really think I did that much, yet they were so grateful

George suffers with Crohn's disease. Despite his young age, just 30, he had had numerous hospital admissions. He had an ostomy and was quite emaciated. He was probably about 5' 10" and only weighed about 115 to 120 pounds. For some reason he was in respiratory distress and was rushed to our ICU to be intubated and ventilated. Despite all his hospitalizations, he'd never been in ICU before.

While he was being transferred to his ICU bed, I couldn't help notice his facial expression. They were bagging him, so he wasn't able to talk, but his eyes said it all. I *remember saying to him, "You don't have to be scared. This is what we're going to do," and I explained it all to him. You know, a lot of patients think that as soon as you put them on a ventilator that they're going to be on it forever. So I also told him that "we don't want this to be a permanent thing. You're just a little unstable right now, and we will get things under control and then take this tube out." You could tell that he was tired and weak, but no longer afraid. You could see him relax. The worry in his eyes just kind of disappeared. His muscles were no longer rigid. The procedure was successful.*

Freeman came to our neuro unit directly from the OR in the wee hours of the morning. He was assigned to me. I'd say he was late 40s, his next of kin unknown. A buddy had found him unconscious in a downtown boarding house. He had a subdural hematoma. The emerg staff called the unit to tell us to expect him. They also alerted us to the fact that his state of hygiene left much to be desired. They suspected he had been unconscious—and incontinent of stool—for a couple of days. He was on his way to the OR for emergency surgery. At that point a bath was not even a consideration.

He arrived from the OR intubated. Once we had him connected to the ventilator that was helping him breathe, I straightened out all his lines and thoroughly assessed him. His pupils were equal and reacting to light. He could be aroused long enough to obey simple commands. He could squeeze and release my hands to command. He could move all of his limbs. Satisfied that his condition was stable and that all was in order, I was ready to start his bath.

I took my time and gently washed him. As I progressed with the bath he started to wake up. His increasing movement had gotten my attention. Immediately, I went up near his face and delicately stroked his arm just above the wrist. Because he was being ventilated, he couldn't talk to me, but his puzzled face expressed his state of confusion. His eyes were full of questions. "Where am I? What's going on? Am I going to be okay?"

Freeman was obviously frightened. In a soft, quiet voice I told him who I was and where he was. I simply explained what had happened to him, why he was here, *what was going on, and the purpose of all the tubes and lines. I assured him that I would be there with him for the rest of the night. I prepared him for some of the routine procedures and tasks that he could anticipate, like checking his pupils and vitals, giving him medication, suctioning him, repositioning him, changing his bed, and so forth. I then continued with the bath.*

When I got to his feet, I soaked each one of them for quite a while in a basin that I had placed right on top of the bed. When I had finished the bath and was ready to do my checks again, Freeman grasped my hand and squeezed it. And while looking directly and peacefully at me, he mouthed the words, "Thank you."

Tammy, aged 19, had been in a very bad car accident. Her long beautiful hair was full of dirt and grit and glass and blood—all sorts of stuff from the accident. Several days had gone by, and no one had taken the time to wash her hair. She was in casts and everything, so she couldn't even scratch her head. She was intubated and couldn't speak, but she could mouth her words.

The first day I was assigned to her I went in after report and hinted that one of my goals for the day was to find some time to wash her hair. Although she was in agonizing pain, she mouthed with a pleading facial expression, "Would you? I can't stand it!"

She struck me as someone who worked out and liked to look her best. I thought that if getting rid of the grit and stuff in her hair would make her feel more like herself, even if it's only for a second, then all the more reason.

Once I got myself organized and figured that I wouldn't be interrupted, I got under way. I gave her enough pain medication to keep her comfortable. It took me nearly two hours to do it, but when I was done she said, "Oh, it feels so good!" She just loved it—the scalp massage, the smell of the shampoo, and the brushing of her hair afterward. She kind of reminded me of a dog who had just been scratched on the belly or behind the ears—totally content.

Bill, a guy in his mid to late 30s, had been gravely ill. He had gone into septic shock. Although he survived the ordeal, his legs had to be amputated below the knee. His stumps were not healing well. He needed to have some grafting done. In the meantime he had become quite depressed.

I noticed that his saline-soaked dressings were getting stuck [to his wounds] and hurt [him] each time they needed to be done. He had been in pain for two or three days. Finally, one night I decided to try putting a nonadherent dressing on before the saline soaked one. Even though I used a different method, I thought it would still accomplish the same thing. It was worth a try.

A couple of other nurses who also knew Bill decided to get involved. They really wanted to create a positive and jovial atmosphere in the room while I was doing the dressing. They arrived in the room with bags on over their heads, looking and acting like clowns.

The next night when we came back in, he showed some life. He said, "I'm so glad that it's you guys that are on. You don't know how much difference that new type of dressing made!" He was more relaxed and in a much better mood. He might not have been looking forward to the dressing change, but he wasn't dreading it either—not like he had been the last while. And so using my knowledge and making a simple bandage change made life easier. He just felt so much better. He hadn't suffered the same amount of pain that next morning. He didn't need so much pain killer that he ended up sedated and depressed for the rest of the morning. He also didn't have to spend the rest of the day anticipating the next dressing change.

Mrs. Snell was my patient today. She is an 80-or-so-year-old lady with aspiration pneumonia. She's a postsurgical cancer patient who had some side effects from radiation and chemo[therapy]. She apparently aspirated and came to us about a week ago for ventilatory and GI [gastrointestinal] support. She was fully alert and interacting with her family, more so than I've seen of any patient, ever. You know, it's easy for us to forget that [i.e., that patients can be alert and are able to interact] at times.

Today being February 29th, I drew a frog to put up on her window. But the frog didn't look right and I said, "I suppose I could go on the Internet, but I don't know how to do that." She quickly responded with, "Why don't you just type in 'frog'?" And in a teasing voice I replied, "How dare you, being 80, and know how to use a computer and I don't!" Well, I finally found a picture of a frog and went, "Yahoo!" Well, she laughed and clapped. She smiled and she felt happiness. Whether it was intentional or not, it was amusing for both of us. But interaction is important for an alert patient who is unfortunately stuck in bed. Humor is one way of doing it. I use humor a fair bit. I often interact that way, rather than the nurse-patient type of thing.

Tara, who was just 16, was burned while cooking with hot fat. She had 30% burns to her arms, chest, and legs. Her face had been spared.

She came to our unit from up north. She was away from home and had no family close by. Over a period of about two months she had at least five surgeries. For the first month she was quite depressed and withdrawn. She spoke little—only when she had to. She never smiled. She was really sad and very homesick. I tried little things to help.

When she couldn't get up and use the phone herself, I put her on the speakerphone so she could talk to her mom. If I went to the snack bar, I would bring back something for her. I would tell her some of my jokes. Her cheer improved little by little. But the biggest change in her was the day I did the makeup and stuff. After her morning care and dressings were done, I got her up in the wheelchair, put some makeup on her, and painted her nails with a hot pink fluorescent polish. I took her for a drive in the wheelchair. She got to show off her nails. When someone noticed, she'd just start giggling. It was a real icebreaker. It just helped to bring her out. It was something that she could share with others that wasn't burn related.

Not too long ago Sandy, a man in his early 40s with Hodgkin's disease, spent his last days with us. He was transferred to our ICU from another hospital. His condition had deteriorated to the point that the need to be ventilated seemed inevitable.

His lungs just weren't able to do the work that they were doing before. He was becoming exhausted just from the work of breathing. He knew things weren't all that good, but he was doing the best he could with the situation.

One evening while I was caring for him, his young son phoned. Just lucky, the phone was close enough that I could bring it to his bed. So I said to his son, "Would you like to talk to your dad? He can't talk to you because he has a tube in his throat, but I'm sure he would love to hear your voice." And, of course, his father already heard me talking to his son and he mouthed, "Yeah, yeah." And so I brought the phone to his ear. His expression was just wonderful! He was thrilled! I could hear the boy talking, but I didn't quite hear what he was saying. But that made his father's day. Yeah, it made his day. He just relaxed after he heard his son's voice. He hadn't heard it for a while.

It's not often that phones are available, but this was an opportune time. So why not take advantage of it?

Mr. Greencorn had been in our unit for quite a while with pancreatitis. He was getting pretty down in the dumps. Numerous cards from his grandchildren adorned his bedside. In another part of the hospital was a newly born grandchild about to go home. He really wanted to see that baby. Most people wouldn't have let that baby in, but I said, "Yes, come, come! Before seven." Well, he just beamed. He was so happy. And after that I noticed that he was more willing to try things—have a little walk or something.

Stan was a post-[angio]plasty patient of mine. The other night while going over his 12-leads, I realized that he had had an inferior infarct that no one seemed to know, or do anything, about. The intern whose attention I brought it to tried to convince me that the elevations [in his 12-lead electrocardiogram] were the result of having been cardioverted that day. I didn't believe him and sent off [some blood to do] an MB fraction. Sure enough, it came back elevated. Because it was still within the time frame [indicated for its effective use], we were able to give him a thrombolytic. Sometimes *your knowledge makes a difference. Stan could have had a lot more damage done to his heart if these drugs hadn't been given.*

One day a young colleague of mine—she'd been in the intensive care unit probably a couple of years—was taking care of a particularly unstable man. She had a couple of drips running, Levophed and Epinephrine. She was having a hard time balancing what she needed to be doing without affecting his heart rate and blood pressure and all these kinds of things.

She's the kind of young person who really likes to do a good job. You can see it in her. She attempts to always do things correctly. But this day I could see that she was tottering a little bit. I could tell from her body language that she was anxious. She was rushing. She was flittering here and there. She was talking very fast. I just knew she needed somebody. I just knew that I needed to be there for a while—to coach.

Luckily, I actually had time this particular day to come over near her [patient's] bedside and kind of watch what was going on. She was sitting there trying to evaluate her steps in maintaining a balance for her patient. She then turned and asked me about what was going on and what she needed to be doing. To be able to help her, I needed some information. My first question was, "When was the last time you changed your drips?" And she said, "Oh, just a couple of minutes ago. But his blood pressure is dropping and his heart rate is up." I calmly said, "Well, you have to evaluate this. What you need to do is, you need to stop. You need to sit still for a few minutes. You need to evaluate everything that's going on with him. I want you to look at his electrolytes. What do they look like? Are they normal? What is his serum osmo[lality]? What are all his numbers? What's his CVP? What's his potassium? What are his other electrolytes—his magnesium, his calcium, and his phosphates? All these things need to be in balance, because if you are trying to maintain him and something is askew, it doesn't matter that you're playing with your drips, the organs themselves actually won't function. So you need to take your time. And you need to figure out if anything is amiss in the values that you already have on your chart. If they're not there, we'll phone and get them done for you." And she said, "Oh, okay." So we went through the chart, we *looked at all of the patient's values, and I said, "Well, they're all pretty good." I said, "We'll look at getting the phosphate. We'll look at getting his osmo." I can't remember if those are the ones exactly, but there were a couple of tests that we added on to the bloodwork that she had sent maybe two hours before. We just called the lab and asked them to do this for us, just to make sure everything is within normal limits. Once we did that she said, "Yeah, but I'm still in a quandary about what drip to do first." And I said, "Well, the rule of thumb here is that they [the physicians] usually don't like the Epinephrine staying on. Depending on what's happening internally, the patient may or may not need systemic support. But the general rule of thumb is to leave the Levophed and work to try and take off the Epinephrine. So what I want you to do is only decrease a few cc's [cubic centimeters] at a time."*

"You know, when a patient is unstable you cannot take big jumps. You have to allow their system time to even out, to smooth out, to accommodate whatever change you've made. So what you do is, you do a few cc's at a time. I don't want you to take a milligram or a whole ug [microgram] at once. I don't want you to take 10 cc's. You might need to take three." "Okay," she said and turned it down three cc's. "Now," I said, "I want you to stand back. I want you to sit down and watch what's going on. I want you to take your time and continue doing that until you get to a point where you realize that you cannot go any more. At that point what the patient's system may require is just a general time out. Or you may discover that you have to give additional fluid. If you can't go any further because of your pressures, but the heart rate is still very high, even for a neuro[surgical] patient, then that may be an indication of low volume.

"Another question to ask yourself is whether or not the patient's pressures fall when you're turning him. If so, then you have another indication of low volume. So just take your time and go down slowly to a certain point. If you can't do any more at that point, and if you're out of the parameters set by the physician, then phone and tell him the whole story. Tell him what's in normal limits, what's not in normal limits, and then you can continue working from there.

"Oh, and one more thing. If you're going to be moving this patient and he's unstable, simply do the movement. Do not do any adjusting of the medications at the same time. Again, take your time. Let his system even out. Know where you're at, and then continue on with the weaning process.

"Remember that when a patient is unstable, there's often many factors happening at the same time. If you make too many changes at once, then you won't know where you're at. And if the patient crashes, then you're going to be in a real pickle! So it's better to take your time."

You know, just working through the steps of weaning this patient's drips with this young nurse helped to calm her down. It helped her to interpret what was occurring on the monitor. It helped her learn what was important to evaluate. It just helped her to be more aware of the many evaluations that we as nurses have to make and when we need to call for assistance. I think just having a bit of guidance and a coach, someone that took the time to be there with her, just helped her to calm down and be more relaxed. Because she became more relaxed, she was better able to deal with the situation. And more than likely she won't be as afraid in the next situation with an unstable patient. She now has the dynamics of how to work through it. She'll know how to handle the patient, and the patient will have a better outcome because his or her physical system will be balanced and functioning properly.

Mr. Evans, a gentleman in his 50s, married with grown children, arrived in our unit from the recovery room following a standard craniotomy [an operation on the brain] to remove a tumor. While I was doing my initial post-op assessment, I found that he was hemiparetic [had weakness on one side of the body]. He was awake—a little drowsy, but no more than you would expect considering the anesthetic and so on. His pupils were fine. He was oriented. He answered my questions appropriately and talked to his wife.

I found out in the recovery room notes that he'd had a grand mal seizure in the recovery room. The surgeon who operated on Mr. Evans saw him in the recovery room and thought that he was fine—that the seizure was just an isolated incident related to *the location of the surgery. He figured that Mr. Evans was hemiparetic because he was postictal [a sleepy state following a seizure]. There was no follow-up, and he was sent up to us.*

I knew there was something more wrong with him. He wasn't your typical groggy postictal patient; he was quite awake. As time went on, about a half an hour or so later he hadn't gotten any stronger on that one side, but he was getting a little groggier. People were still saying, "It's the anesthetic" or "He's postictal." But I argued that if he's postictal or if it's from the anesthetic, he wouldn't have been as bright as he was when he came up to us. In fact, he'd be getting better or he'd be the same; he wouldn't be better and then getting worse. His hemiparesis wasn't getting better, so I phoned the resident on call to come and examine him. He went and examined the patient. He came out and said, in his condescending way, that the surgeon who performed the surgery saw him in recovery, was not concerned, so neither was he. But as far as I was concerned, there was something wrong, and this patient needed attention! As I was about to pick up the phone to call the chief resident, who had also seen this patient in recovery, the staff man called, so I told him instead. He came down to the unit right away. He then sent Mr. Evans for a stat CT [computed tomography] scan. Sure enough, Mr. Evans had had a huge epidural bleed. Inadvertently, they had nicked an artery during surgery. They whipped him right back to the operating room. They stopped the bleeding, removed the clot, and he was fine.

When the resident came back, I was actually quite angry with him. Without mincing my words, I said to him, "When I tell you I'm concerned about somebody, it's because I'm concerned about somebody!" And I said, "If you don't know what to do, get somebody else who does!" I said my piece with him. When I went home that night I felt good about myself. I thought, "You know, I picked up on it and trusted myself enough to go further with it." Luckily, the surgeon that I talked to knew me and knew that if I was concerned, then, based on my experience, there was reason to be concerned. I went home thinking, "Well, that was a good save." And it's not an ego thing. It's just that I knew [that] there was something wrong, and I sort of have that peace of mind of acting on it.

Mrs. Wong, an elderly Chinese lady, had extensive bowel surgery three months ago. She'd been in the unit all that time. Her kidneys had failed, and eventually she got pneumonia. The first day I was assigned to her, she was still being ventilated. She had been on 24% oxygen for days. She was just lying there in a KCI bed. She was skin and bones. She couldn't speak a word of English.

I like to do things, so my first thought was, Why aren't we doing something with this lady?" I like to believe that everybody will get out of ICU at one time or another. I like to believe that if there is something that they can maintain while they are in the ICU, some function of normality, then they should. It's a very important thing. So I asked the staff man, "What do we have planned? What are the short-term goals here, and what are the long-term goals?" Well, the short-term goals are to improve the pneumonia. The long-term goals are to send her to a pulmonary unit.

I always like to have a plan. If you don't make a plan, it's easy for the boys [the doctors on rounds] to just walk by day after day. So I said, "She's been on 24% for a long time. She's been here for three months in this KCI bed. We need to do something." The response was, "Well, what would you like to do?" "Well, have we tried to extubate?" "Well, we wanted to trach her, but the family wouldn't let us because they'd heard of somebody who had bled to death with a trach." So I said to the staff man, "Okay. Well, why don't we try extubating her? She's been on 24% for about a month, and we're not doing anything for her, and I think we should start getting her up." So we made a three-day plan. He said, "Run her hemo [hemodialysis] today; we'll extubate her tomorrow." "And get her up in a chair," I added.

So that's what we did in three days. We extubated her, got her up out of bed and into the chair, and she eventually got out of the unit. Otherwise, she would have passed away in ICU with an endo[tracheal] tube hanging in her face, never able to speak to her family again. Sometimes there's that window of opportunity. You have to try and get there whenever you can. And I think that is making a difference.

I like to snoop around and see how the patients I had are doing. One day on my travels I found this man who was struggling. He was totally hypoxic. He was on a non-rebreather mask, restrained in his bed. Apparently on nights he had been restless, so they tied him up and sedated him with Versed and Haldol. When his nurse went for coffee, I got him up in a chair, soaked his feet, bathed him, and gave him a little exercise. The physio[therapist] and I cleared out his chest. I suctioned the back of his nose and got him to cough. The secretions were thick like glue. It's no wonder he was hypoxic and restless! Talk about a vicious circle. They were just throwing more fuel on the fire rather than getting to the root of the problem.

My policy is to say no to drugs. If someone is restless, I get them up. Besides, most normal people spend most of their life sitting up or getting up. It must help you to get better because you know that you haven't died and gone to hell. If you can actually touch the floor with your feet, maybe there's hope.

When we got him back to bed, he allowed us to lie him flat on his back while we did postural drainage. He was totally cooperative and just about fell off to sleep. He was so much better now that he was able to breathe easier. Would you believe that he was transferred out of the unit the very next day?

Mrs. Smith, a woman in her sixties, had surgery to evacuate a subdural hematoma. As her oncoming day nurse, it was reported to me that she had been confused and agitated overnight. Apparently there had also been a physical confrontation. She needed to be restrained. She was also started on Loxapine.

I don't know whether it was the fact that they had started her on some Loxapine or not, but I didn't have a problem with her. I took her restraints off. I let her be however she wanted to be, to be comfortable. And I just talked to her gently.

As the day progressed I realized that this lady was not confused, but rather had a very off-the-wall sense of humor. I also discovered that the more her husband wanted her to be serious, the more agitated she became. I actually fit into her being humorous. When I helped her up out of bed, I looked at her and said, "Now it's time to dance."

We danced at the bedside. Humor really worked with her. I could get her to do anything. I got her to walk; I got her to exercise; I got her to [deep] breathe.

Unfortunately, that night the same nurse restrained her again. As soon as she saw me the next morning, she started to cry. When I asked her what was wrong, she couldn't quite get the words to work, but it was something like, "They're treating me like I'm on a psychiatric ward." I truly believed that she wasn't out in left field. She was certainly aware enough and had been hurt by the ordeal. That day I only gave her one dose [of the medication]; I didn't have a problem. We had a couple more dances. I discovered that because of some balance problems, dancing was easier for her than walking. Before I left that day I made sure to write it in the Kardex that this woman likes to use humor to deal with situations. That's what I thought about it, and that's how we worked together.

I took care of Ernie off and on over a period of about two weeks. He was a bad COPDer [chronic obstructive pulmonary disease]. Bad! He had been in the unit for about three months by this time, trached and ventilated. He hadn't been out of bed, not even into one of our new fancy Geri chairs. He wasn't doing much other than helping turn in bed. His affect was very flat. He was down and out.

We had just started his plugging trials. It was now the weekend. On my first day with him I asked him his age. He told me he was 70, and I said, "Oh, the Oil of Olay looks good on you."

It was a very warm day with a nice breeze. So later I suggested that we get him up into a Geri chair and during his plugging trial take him outside for a suntan. I asked him how he would like that. He was somewhat hesitant in his response, saying, "Oh, my!" But he was willing to go along with the plan, so I got the doctor's order and the whole ball of wax. I got the portable monitor and made arrangements with the RT [respiratory therapist]. The only thing we didn't have was suction.

When I first suggested that he was to stand at the side of the bed, he thought he couldn't do it, and I said, "Oh yes, you can!" I said, "It's gonna be tough, but we're gonna do this. You're gonna waltz with me, and we'll do it."

Well, lo and behold, he wanted to use the bedpan. So I thought to myself, Here is our opportunity. He's still hooked up to the vent. He's got good oxygen. So I said, "Tell you what, we're going to do this while you're sitting up and still hooked up to the vent." He went, "Huh!" I said, "Watch this, we'll do it." You know how uncomfortable those things are to use in bed. So I put the bed, these new funky beds we have, up in a chair position and sat him at the side of the bed. I said, "Now rest here for a couple of seconds." I then asked him if he was dizzy. He said, "Oh, not too bad." I'm very good at reading lips.

I then stood him up on his feet. He was just shocked that he could stand. I quickly slipped the bedpan underneath him and sat him back down. He had great results without a scrunched coccyx! He thought that he was the cat's meow!

He eventually got to sit outside for about 10 minutes and go for a 20-minute jaunt in the Geri chair. I was the first nurse to take him outside for a suntan! Because it was one of his first few days of plugging trials, he didn't last as long as he would have liked. But oh, he saw the leaves blowing in the trees, and he enjoyed the breeze.

After that day I noticed that his affect and stuff had brightened up. He opened up a lot more. Even though it took a bit of exertion, he talked more when he was plugged. He gave me a few high fives and wrote notes to me.

Not even two weeks later I got him out of bed and sat him in a regular chair. I shaved him, shampooed him, and soaked his feet. It was the closest thing he had to a bath. He sat up for a whole hour and even took a couple of steps. He realized he was a lot better at standing and pivoting. We talked about it and I said, "See, I told you it would be hard when you first started," and I added, "It's still hard, but look at how much more you can do now than you could two weeks ago, not even two weeks. And if you keep up with your exercises, you'll be able to stand up and walk on your own again." He looked at me with a mischievous grin and said, "Yes, boss!" He then told me I was a very good nurse. I think he really appreciated my efforts. He said as much the other day when I dropped by to check on him. Every time I'm nearby, he makes sure he lifts his legs and lifts his arms for me to see.

Jimmy, a young fellow in his early 20s, was in our unit for a month and a half or something like that with some type of debilitating muscular disease. When he improved somewhat, we decided to take him outside. The first day we went just outside the door; it was a bit cool. The next day we went again; it was warmer. We went a little further, far enough to discover that where he really wanted to go was to the pizza lounge across the way.

He was familiar with the area and asked if he could go. It wasn't okay, but one day we took him there anyway. He still needed to be ventilated, so we had to bag him the whole time. He couldn't have anything to eat or drink, but he was just so happy to go and sit in there for a while. He grinned from ear to ear and asked to go back the next day. I think it just gave him a little bit of oomph to live. Yeah! And I think he just thought he was that much closer to getting out.

Doug was a young fellow in his 20s, married, with two small children. He was in a motor vehicle accident and instantly became quadriplegic. He wasn't intubated at this point and could still talk. However, he was still having some spinal shock. He couldn't really do much more than shrug his shoulders. He had no feeling from the nipple line down.

I had been his nurse for about a day and a half when his wife and children had to return to their home up north. They weren't going to be seeing him for a while. His kids came into the unit to say goodbye to him. His young daughter came in, said goodbye, quickly left, and that was it. But then his little boy came in to say goodbye to his dad. He was truly upset that he had to leave his dad. The dad was quite emotional too. He wasn't crying, but you could tell he was trying to keep it together for the sake of his son. There was just the dad and I and the young boy. His head just came up to the top of the bed, so I pulled the curtains and I lifted the little boy onto the bed. I told him that it was okay to hug dad and to give him a kiss before he left. As the little boy leaned over to give dad a kiss, I took the dad's arms and hugged the little boy. I stepped outside the curtain and just let them be.

Now that I have my own children I find that I look at things completely different. I just couldn't imagine the grief of knowing that you were staying in that condition and having to say good-bye to your children.

Dad said good-bye. He cried lots. When the little boy came out from around the curtain, he was fine. He was still sad, but he wasn't crying. He all of a sudden threw his arms around my hips. I got down on the floor to talk to him, and he said, "I'm going home now, but I want to thank you for taking such good care of my daddy." And I said, "You're welcome, sweetheart. You know we're going to try to get him home to you as soon as we can. I don't know when that will be, but we're trying." He then said, "I know," and turned and walked out the door.

I went back in and talked to the dad for a while. We both cried a little while together. And then I said, "Okay, now you need to work to get home to them, and I'm going to help you get there. Are you ready?" He said, "Yes." Even though he knew he wouldn't walk again, I think the incident gave him something to look forward to in a very real way. He just couldn't lay there and give up on life. We never, neither one of us, ever referred to that incident again. He ended up having to be intubated and ventilated, but we got him through all that. We did get him home.

I knew how much it would mean for them both for the dad to be able to hug his son, so that's what I did, and it worked! It didn't matter to me what anybody else thought. I just pulled the curtains, and I thought, It's a private time, and did it.

Colin, a 50-year-old patient in our unit, had some pretty decent burns from a gas explosion. He had had some grafting done and was healing. It was nearing Christmas.

Before his injuries he had decided that he wanted to marry his girlfriend. He had even purchased the ring that they had seen together some time ago. They had been together for several years. He was going to "pop the question" at Christmas. But because of his burns, he wasn't sure if he should follow through with it. Because we were there for support, he would sound out every nurse that came in. He'd ask, "What do you think?" We were able to share what we knew from other patients' experiences.

But not having been through it, we couldn't share from our personal experiences. One day when I was assigned to him, I offered to call a burn survivor to come in and talk to him. He agreed. It seemed to help him a lot to know that he was not alone out there. He discovered that he was not the only one who'd been through this; others had survived, and life goes on.

After that visit he made up his mind. The plan to propose to his girlfriend was still on. Christmas Day was going to be the day.

On his behalf, I made plans too. I set up a romantic Christmas dinner for them in his room. I pulled the curtains so no one would go in. I put a couple of over-bed tables together. I used a small draw sheet as a tablecloth and put a candle in the center of the table. I ordered turkey dinners from the kitchen.

Boy, was his girlfriend ever shocked when she arrived and saw the set-up. Finally he asked, and she accepted. You could hear the whooping and hollering in there. She had been waiting for this moment for months. They were married a few months later. Just being there for support and doing a little extra for a special occasion helped him realize that life goes on.

CHAPTER 6

ILLUMINATING THE MEANING OF "MAKING A DIFFERENCE" IN CRITICAL CARE NURSING PRACTICE

> "While we can never really show the fullness of lived experience, we must dare to say something" (Montgomery-Whicher; as cited in Cameron, 1998, p. 125).

When critical care nurses talk about making a difference, about what do they speak? Seek not to answer the question, but to live in the question with understanding (Olson, 1993).

"As soon as we have the thing before our eyes, and in our hearts an ear for the word, thinking prospers" (Heidegger, 1993, p. 343). This chapter is the dwelling place of an interpretive-descriptive text, a textual expression of the meaning of making a difference in critical care nursing practice. It is the space that has been created for one to dwell with reflective understanding, a place within which one can relive and reflect on the meaning embedded in this lived experience. In turn, it is a place where the artful dimensions of critical care nursing practice may be uncovered, discovered, and perhaps recovered.

There is no doubt that the onset of critical illness makes a difference in the lives of those who have fallen victim. Life-threatening disease or injury abruptly changes the lives of its victims, ransacking their bodies and shattering their worlds, and even before the critically ill have passed through the doors to the battlefield of the critical care unit, they have entered a new existential state, a state of limitless vulnerability (Gadow, 1995; Pellegrino, 1985). Yet they courageously engage in what is most likely "the battle of their lives"—their battle against death, their battle for life.

In fighting the battle the critically ill are necessarily held hostage and, ironically, become the targets of attack by the joint forces who fight on their behalf. As ever-innocent casualties, they sustain wounds and insults that add to their victimized state—increasing their pain, escalating their dependence, curtailing their control, diminishing their strength, abating their will, and, subsequently, intensifying their suffering and heightening their vulnerability.

However, there is a notable force who, given their position, can make a difference in the lives of the critically ill as they rage their battle. They are the critical care nurses—the ones in the trenches, on the front lines. They are the caring force who take up battle, not in response to a command by some higher authority, but rather in response to the call of the vulnerable who need their care. The vulnerable call them to responsibility; they call upon them to act "responsively and responsibly" (van Manen, 1991, p. 97).

As Echo Heron (1987) chronicled her voyage as a critical care nurse in the novel "Intensive Care: The Story of a Nurse", she described her experience of the call by "those who carry deep wounds" as a "knowing of the heart" (p. 12). She stated, "From the start there was no other choice; my purpose was to touch the wounds of others and then to heal" (p. 12).

The French philosopher Emmanuel Levinas (1998) uses the phenomenology of the face to help us better understand this experience, this call to responsibility. For Levinas the face is a mode in which the vulnerable other is revealed, and as the other's vulnerability is revealed, one discovers that one is called to responsibility. He states, "What is meaningful in the face is the command to responsibility" (Levinas; as cited in Rötzer, 1995, p. 61). Elsewhere he explained that "the face [of the other] summons me, calls for me, begs for me, and in so doing recalls my responsibility" (Levinas; as cited in Eifried, 1998, p. 36). Thus it is in the face of the other that we meet the other in his or her vulnerability, and in the face of the other's vulnerability, one recognizes one's responsibility for the other. The face of the vulnerable other is experienced as a voice, as an appeal. One is called upon to respond. In responding to the call, one overcomes one's self-centeredness and enters into an ethical/moral relation with the other, a relation in which one fulfills one's duty (as in responsibility) to foster good in the other's life. It is this sense of the nature of the "call" that now gives a newer and deeper meaning to such common expressions as "the call of duty" or "duty calls." Furthermore, it is this meaning that also reveals the deeper sense of what we mean when we speak of nursing as a vocation, as a calling (van Manen, 2002a).

As critical care nurses "responsively and responsibly" (van Manen, 1991, p. 97) respond to the call of duty, what good do they foster? As they take up battle, what difference do they make? Consider the following text an invitation to dwell reflectively in the lived meaning of making a difference in critical care nursing practice, guided by the following themes: making the inhumane humane, making the unbearable bearable, making the life threatening life sustaining, and making the unliveable liveable. Bear in mind, however, that, despite the illusion of order created by this thematic sequence, these themes of lived experience are always simultaneously at play and that, given the complexity of lived experience, they are not necessarily mutually exclusive.

Making the Inhumane Humane

"Nursing is still the beacon for humane care" (Ray, 1997, p. 170).

Aside from the fact that humans engage in battle, it is unlikely that anything even remotely humane is evoked by images of battle or by any of its synonyms—fight, combat, or warfare. The connotation of a battle seems antithetical to anything humane. Accordingly, a battleground would, in all likelihood, seem to be an inhumane place. Indeed, that is how the battleground of the critical care unit has often been viewed—as an "inhumane place" (Dracup & Bryan-Brown, 1995, p.1). Subsequently, in the quest to defeat death, the enemy, and to fight disease or injury, the critically ill, as the targets of attack, are sometimes subjected to what are perceived to be inhumane acts—brutal, cruel, harsh, savage, vicious, or barbaric. Even as the critical care nurses talked about their experiences of caring for the critically ill, they used such expressions as "*attack,*" "*invade,*" and "*torture*" as they described the "*infliction of pain,*" the "*poking and prodding,*" and the "*many invasive things*" that are done to the critically ill during the course of diagnosis and treatment in the critical care unit:

> *We do a lot of things that almost seem like attack to people because they're foreign and they hurt and they're just not the usual. Oh yeah, strange place, strange people.*

In her novel Echo Heron (1987) recalls a former 84-year-old male patient who did not want to be resuscitated. After having had a major heart attack and receiving a recent diagnosis of an aortic aneurysm, he was certain that, in the event that something happened to him, he wanted to be "left alone." He did not want any "hoses" to be put into his lungs or to be put on "those machines" that keep people alive. As far as he was concerned, "all these modern drugs and equipment are just a way of messin' around in God's workshop when His back is turned" (p. 215). During Echo's weekend off, however, his condition had deteriorated, and his family had coerced him into allowing the doctors to insert several lines. Not long after the lines were in, he went into ventricular tachycardia, and the team ran a full code (resuscitation) on him. This is how she described the horrific event of her return:

> When he saw me, he tried to talk, choked on the endotracheal tube, and went into a spasm of coughing, his face turning red and ugly. Dark purple and yellow bruises covered his arms, and his wrists were scraped raw from his struggles to free himself from the restraints securely tied to the side rails.
>
> Every orifice held a tube: there was the endotracheal tube in his mouth, along with a bite block forcing his jaws apart; a tube down his nose that went into his stomach; the pulmonary line threaded into the external jugular vein; two IVs in his left arm and one in his right; an arterial line in his groin; a urinary

> drainage catheter running through the urethra and into his bladder; and yet another larger catheter had been pushed into his rectum to aid the draining liquid stool. It was everything he didn't want.
>
> The noise of the respirator alarm and the raspy sound of mucus rattling in the endotracheal tube mocked him as he opened his mouth and made a silent scream. He shut his eyes tightly, and tears ran down the channels of his wrinkles. (pp. 224-225)

In reference to the above, Tisdale (1986a) would no doubt be critical and consider this scenario to be but one more example of how those who fight the battle of modern health care use "great machines, bloodless and wise, to beat the body into longer life" (p. 430). Dramatics aside, however, most critical care nurses would, in all likelihood, agree that in many respects this story captures some of the more inhumane aspects of the experience of critical care—the invasiveness of tubes and lines, the woundedness of inflicted pain, the torture of being tied and tethered, and the entrapment of a muted body.

More subtly, perhaps, this scene also brings into awareness a subsuming theme, that of the experience of de-humanization that may arise out of events associated with critical illness and critical care. The scenario above illustrates several sources—the indignity associated with critical illness itself as well as its associated care, the invasion of privacy, and the infringement of autonomy. During a period of critical illness and diagnosis and treatment in the critical care unit, the potential to experience de-humanization is thus real and ever present. A critical care nurse somewhat captured this sentiment in saying:

> *We take everything away from them [patients]—we take away their dignity, their control. . . . We take away every facet of what makes a person a person.*

Although the prefix *de* suggests, as does the nurse's statement, that in the process of de-humanization "*we take away*" a person's human-ness, we know that, literally, this is not possible. Then we must ask ourselves, What does take place when one is de-humanized? To better understand this experience of de-humanization, however, we must first grasp the notion of what it means to be human. What does *human-ness* mean?

A human is a being with subjectivity who thus possesses inherent dignity (Gadow, 1984, 1985). It is this subjective being and its associated dignity that morally distinguishes humans from objects. Hence, subjectivity is the quintessence of human-ness. Furthermore, in the phenomenological and existential sense, the experience of being human is one of embodiment. The subjectivity (a.k.a. the self or the lived body) and the physical body of the human are integrated and unified, and as an embodied being, the human experiences a sense of wholeness, a sense of completeness.

However, in certain circumstances, particularly in situations of critical illness and critical illness care, this unity of human existence may become dis-integrated. The human may become dis-embodied and, subsequently, experience a sense of being reduced to an object. In the process, human dignity is violated (Gadow, 1984, 1985), and the human person is de-humanized (Travelbee, 1971).

For example, with experiences such as pain, dysfunction, or disfigurement, the naturally silent or taken-for-granted (healthy) physical body announces itself as an object (Bleeker & Mulderij, 1992; Leder, 1990; Sartre, 1956; van Manen, 1998). The object nature of the physical body is discovered and, at least for the time being, cannot be forgotten. Thus the normal unity of human existence is disrupted. The object physical (objectified) body, now alien to the self, becomes the center of one's experience at the expense of one's subjectivity; and, with subjectivity stifled, we thus speak of the indignity (de-humanization) of illness (Gadow, 1984, 1985). So too when the object body is brought into one's awareness one becomes conscious of the self as a body, and thus we commonly speak of the experience of being self-conscious.

Likewise, if, during the course of diagnosis and treatment, the physical body becomes the central or sole concern of others, the human may experience the physical body as an object—a thing, a disease to be investigated, a disease to be treated. Thus the human can become dis-embodied and the physical body objectified from sources outside the body as well as from within. As subjectivity (*"the person inside the body"*) is forgotten, ignored, excluded, or marginalized by others, dignity is violated; and as the human person is reduced to the status of object, the human person becomes de-humanized (Gadow, 1984, 1985, 1989; Travelbee, 1971). At times it may be necessary for others to treat the physical body solely as an objective reality, as, for example, in assuaging the immediacy of an illness-related event. However, this experience of dis-embodiment by others becomes particularly problematic when there is persistent regard for the body as a mere object and hence exclusive disregard for one's subjectivity. Within the context of the current theme, any further reference to dis-embodiment will primarily be in relation to dis-embodiment from without.

Undeniably, the use of complicated technology in the critical care unit is a major culprit when it comes to undermining dignity and thus de-humanizing the critically ill. However, as Gadow (1984, 1985) pointed out, this is not because the technology itself is an inherent indignity, but rather because, in its complexity, technology seemingly has a reality of its own and asserts a sense of otherness in two forms. First, the technology itself asserts an otherness that cannot be ignored or easily integrated into the subjective experience of the patient. The now technologized physical body becomes categorically other and alien to the self. As Olson (1993) explained, "The patient may feel like the junction of tubes and wires, the extension of a machine, or even the target of a machine" (p. 150). Second, technology commands the serious attention of those who must manage its complexity. In both situations the technologized physical body becomes the central focus, to the exclusion of subjectivity. Thus dignity is violated, and the critically ill patient is reduced to the status of object. In other words, the critically ill patient is de-humanized. Similarly, Cassell (1991) refers to the seductive power of technology and reminds us of how easily this phenomenon can occur in the critical care unit as he described how, when simply approaching the bedside of a critically ill patient, all eyes go to the machinery rather than to the patient and how effort is often required to "not" watch the monitors.

As one considers the underlying nature of de-humanization—that is, as a process of objectification—one may now recognize other, perhaps more subtle, experiences of de-humanization. For example, as Sartre (1956) suggested, a human can be made to feel like an object simply by the look of another. Consider the following excerpt from a critical care nurse's story about physicians' rounds on a critically ill patient whose leg had been showered with emboli (blood clots) as an illustration of the objectifying look:

> *They lifted up the sheet, looked at her leg, put the sheet down, and never even talked to her. They just kept on looking and looking. She was totally awake and could see them. She couldn't feel any pain, but you could just tell that she was upset and concerned. You could just read it in her eyes.*
>
> *She was intubated, so she couldn't talk. But it was as if her eyes were asking, "Why are they looking at my leg? What's wrong with my leg?"*
>
> *She was very alert. She knew there was something seriously wrong. But I didn't think it was my place to tell her. It wasn't as if they [the physicians] couldn't talk to her or that, if asked, she couldn't make decisions. They [the physicians] ended up doing what they wanted to do. They took away her control, her dignity, and her human-ness. Why can't they talk to these people? Just because they [the patients] can't talk doesn't mean that they can't hear, see, understand, think, and feel. They're not like dead! It was a horrible experience.*

In conducting rounds on this patient, it is evident that the physicians who looked her over clearly overlooked "her". By disregarding her subjectivity, they made her feel like an object. As the object of their clinical gaze, she experienced herself as object or, perhaps more fittingly, as "an object with interesting peculiarities" (van den Berg, 1966, p. 97). In spite of the fact that she apparently did not feel any physical pain, it is apparent that she underwent a painful, de-humanizing experience as a result of not being acknowledged. van den Berg's (as cited in Drew, 1986) description of the phenomenon of de-humanization offers a plausible account of this patient's experience of rounds and, no doubt, the experience of rounds for many others:

> When excluded we see ourselves and our bodies as undesirable, unwanted, and we cannot inhabit our bodies easily and freely as we would when we feel accepted and confirmed by others. There grows a split between body and mind; we become embarrassed, ashamed, self-conscious. (p. 39)

Thus far, considerable attention has been given to the notion that reduction of a critically ill patient to the status of object, void of subjectivity, poses a violation of dignity and thus is a form of de-humanization. Gadow (1984), however, also posited the idea that such reduction also violates the value of autonomy, given that, denied one's subjectivity, the critically ill patient no longer has any special authority when it comes to making decisions about the care of his or her body. With decision making based solely upon the external, clinical interpretations of others (the professional objective view) and not upon the meanings and values of the patient (Gadow, 1989), it can be argued that this denial to exercise autonomy (an aspect of human-ness) in decisions about the body's care is also a form of de-humanization. Could this experience not also account for some of the upset that the nurse witnessed in the eyes of the critically ill patient in the above scenario whose right to self-determination was not even a consideration as "*they [the physicians] ended up doing what they wanted to do*"? Could it not also account for the tears of humiliation and betrayal from Echo Heron's (1987) patient when his previously expressed wishes to be "left alone" were disregarded and, instead, he got "everything he didn't want"? Is it not this process of de-humanization that, in turn, may account somewhat for the ease with which the critically ill are sometimes subjected to what are perceived to be inhumane acts that, particularly in situations where there is no possibility of a cure, act to prolong death rather than life or intensify the experience of pain rather than ease suffering?

In talking about their experiences and telling their stories, critical care nurses attested to the inhumane nature of the critical care unit and to the de-humanizing nature of certain events associated with critical illness and critical care. Yet at the same time their experiences and stories attest to their abilities to make a difference by humanizing their patients' experiences of critical illness and critical care. In a myriad of ways critical care nurses act and interact to make this inhumane place more humane and to counteract the de-humanization associated with life-threatening disease or injury and being held captive for diagnosis and treatment in the critical care unit.

Acknowledging Human-ness

"The act of acknowledgement is probably the single most healing capacity we have as human beings" (Tufts; as cited in Schweitzer, 1994, p. 45).

"And the ill have appealed to the healer to be seen as a whole person, or, failing that, just as a person" (St. Vincent Millay; as cited in Styles & Moccia, 1993, p. 83).

Humanizing the experience of critical illness is contingent on the willingness of critical care nurses to heed the call of the critically ill to be seen as humans (subjects) and not as mere objects—not as machines with broken parts that require fixing, not as "*toys*" for experimental "*play,*" and not as targets for the latest and most powerful weapons. Hearing this appeal, several critical care nurses described their fundamental responsibility to the vulnerable in their care as follows:

> *You have to stop in all that madness and realize you're dealing with a person.*

> *You have to see the patient as a person, not as a problem. You have to see beyond the illness. You have to see beyond the pumps, the ventilator, and the bed.*

> *You have to remember that at the end of the machines there is a human being who lives and breathes and does other things.*

> *You have to treat the patient as a human—not just a number or a diagnosis, but actually somebody with a name and feelings.*

Thus in addition to competently attending to the diseased and injured bodies of the critically ill and skillfully managing the associated technology, these critical care nurses also acknowledge the importance of acknowledging the human-ness of those in their care. They seemingly hinted that such acknowledgement is of value and that an important or significant difference can be made when "*the person inside the body*" is remembered, when the some-body inside the body is recognized.

From an existential perspective, this acknowledgement of human-ness by critical care nurses means showing regard for and engaging the subjectivity of the critically ill in their care. It means seeing the critically ill patient as a human presence and responding to the patient as a human person in his or her vulnerability. It therefore requires the subjective involvement of the nurse and thus the establishment of a relation of intersubjectivity. Bishop and Scudder (2001) describe this relation in which critical care nurses engage the subjectivity of their critically ill patients while necessarily attending to their diseased and injured bodies as objective realities as the I-It (Thou) relation, a relation they derived from the work of existentialist Martin Buber. And as Gadow (1984, 1985) and Kleiman (2005) point out, it is by establishing this primordial relation with the critically ill that their dignity is respected and, subsequently, that their experiences are humanized.

Yet one wonders how critical care nurses acknowledge the human-ness of their critically ill patients. What does this acknowledgement entail? How do the critically ill experience this acknowledgement? Or what difference does it make in the experience of the critically ill?

In describing a personal experience of being excluded by a nurse when she herself sought emergency treatment for an eye injury, a critical care nurse remembers how this very "*impersonal*" encounter with a nurse made her feel that she was "*unimportant*" and "*just a pain.*" She recalls:

> *The nurse came in to check my eye. She didn't say hello to me; she didn't do anything. She just pulled down the snellen eye chart, gruffly asked me to read it, and then snapped it back up and left. And that was the end of it.*

In carrying out her tasks, this ER nurse was mechanical, emotionless, aloof, and rushed. Although she said little verbally, her demeanor clearly expressed her disregard for the patient's human-ness and her distance and detachment from the patient's situation. For those of you who have ever been in situations in which you were not even accorded the social recognition that would be expected in such circumstances, it is not difficult to relate to how this patient must have felt. For those of you who have ever been ignored, snubbed, or given the "cold shoulder" by someone from whom you expected otherwise, you no doubt remember well a feeling of being in-visible, in-significant, or in-valid. Perhaps too you might recall that, suddenly, the world went gloomy and dark and the flowers lost their color and the sun its brightness (van den Berg, 1972). How different the experience could have been for this patient had the ER nurse simply extended a warm greeting, cracked an open smile, offered an accepting touch, or affirmatively glanced the patient's way. The patient would have been confirmed as a human person. The patient would have, in effect, been truly seen (Jourard, 1968).

A much different encounter occurred between Philip and his nurse. If you recall, Philip was the middle-aged patient who, after unsuccessful coronary angioplasty following his fifth heart attack, was informed by his physician that he would require bypass surgery. On the day that he received this shocking news, his day nurse described his behavior toward everyone, including his wife, as agitated, rude, and demanding. At report she suggested to his night nurse that he best be avoided outside of completing the essential tasks. His night nurse, however, remembering that "*the most difficult patients are often the ones who are scared, lonely, [and] nervous, [had] other plans*":

> *When I walked into his room that night with his pills I said, "Hi, I'm _______, I'm your nurse for the night. I know I'm a poor excuse for a Friday night date but, unfortunately, you're stuck with me." He laughed at that point, but we had a good talk later.*

How fortunate for Philip that he was stuck with this nurse for the night. In her verbal greeting alone, this nurse acknowledged him as a human presence. With her little twist of humor, he quickly sensed that her greeting encompassed more. Yes, he was stuck with her, but in a manner of speaking, she was also going to "stick with him." She was going to be his nurse, his trusted ally. It didn't take him long to grasp some idea of what this meant. In his vulnerability he keenly sensed her genuine message of availability, a sharp contrast to the messages of avoidance he received earlier. To this nurse he wasn't just an inconvenience, a nuisance, a bother, or a troublemaker. To this nurse he was important. To this nurse he mattered.

Philip's nurse had great insight into his overall situation, and she knew the underlying meaning of his so called "*difficult*" behavior. She was therefore able to look beyond—to overlook—his behavior. She knew that his situation called for something other than avoidance. She, like van den Berg (1966), knew to expect such difficult behavior given that the sickbed had dictated to him the task for which he was least prepared—"the confrontation with the vulnerability of his body and the transience of his life" (p. 50). Thus, instead of avoidance, she indirectly offered him the assurance that she knew he so greatly needed during this time of terror, the assurance that she would be there:

> *At one point he was in tears. He talked about his recent heart attack, his prognosis, and his planned surgery. He told me he was so terrified that he didn't know what to do. He said that he felt that people were avoiding him and that he didn't have anyone to talk to. I explained some things, but mostly I sat and just listened.*

Although the description of the world of critical care may suggest that differences in critical care nursing practice are made only by doing (e.g., procedures, tasks, and protocols), this encounter between Philip and his nurse suggests that differences are also made by being—being present to another in a particular moment of crisis or need. Aware of Philip's current state of vulnerability, this nurse offered him the gift of her presence.

What is presence? The word presence is of Latin and French origin. It derives from the word *praesens* (*prae*, which means 'in front,' and *sens*, which means 'being')—the same word as the verb *presentare*, which means 'to place before,' 'to hold out,' 'to offer,' from which the nouns gift and present evolved (Onions, 1966). Doona, Hagerty, and Chase (1997) defined the presence of a nurse as "an intersubjective encounter between a nurse and a patient in which the nurse approaches the patient as a unique human being in a unique situation and chooses to spend herself [or himself] on the patient's behalf" (p. 12). Presence is more than the sheer physical presence of "being there" with the other in the same place, at the same time. Presence also connotes a "being with" the other, a living personal presence that transcends space and time. In being with the patient, the nurse offers or holds out to the patient the gift of his or her being.

Marcel (1948) suggests that it is only open, receptive, or available persons who reveal presence:

> There are some people who reveal themselves as 'present'—that is to say, at our disposal—when we are in pain or in need to confide in someone, while there are other people who do not give us this feeling, however great is their goodwill. . . . The most attentive and most conscientious listener may give me the impression of not being present; he gives me nothing, he cannot make room for me in himself, whatever the material favours which he is prepared to grant me. The truth is that there is a way of listening which is a way of giving, and another way of listening which is a way of refusing, of refusing *oneself*; the material gift, the visible action, do not necessarily witness to presence. . . . Presence is something which reveals itself immediately and unmistakably in a look, a smile, an intonation or a handshake. (pp. 25-26)

In qualifying statements, Marcel later adds:

> It will perhaps make it clearer if I say that the person who is at my disposal is the one who is capable of being with me with the whole of himself when I am in need; while the one who is not at my disposal seems merely to offer me a temporary loan raised on his resources. For the one I am a presence; for the other I am an object. (p. 26)

In this latter statement regarding the nature of presence, Marcel (1948) alludes to presence as involving mutuality and thus having a confirming quality. As Philip's nurse revealed her presence to him, he was also seen as a presence. He was seen as a human rather than an object. In being with him, his nurse responded openly and willingly. As she listened attentively, she gave of herself. Knowing that her desire to help was authentic and that his well-being was her priority, he sensed his worthiness.

His dignity (L. *dignitās*, which means 'worthy') was affirmed. Thus, this experience was not objectifying, but rather humanizing.

Moreover, with the nurse's initial use of humor, she created an atmosphere of warmth and acceptance that allowed for a more serious conversation later. Trusting that he would not be judged or ridiculed, Philip openly expressed his true thoughts and feelings. Indeed, his nurse had created a safe, non-threatening place for him to share the secrets of his vulnerability. And as in any good conversation, the nurse's silence was as important as her words (van Manen, 1991):

> *And he was a lot more relaxed after that. He was very pleasant to me. He didn't complain when I asked him to get up or let me do his bloodwork. But the big thing was that he slept that night, the first time in days.*

The silence of her listening ear invited him to tell his story and thus reduced the chaos that had been created by the recent adversity in his life (Charon, 1996). By being given the chance to also "hear" his story, he was able to clarify his thoughts and discover his feelings (Nichols, 1995). His world then became quiet enough for him to sleep. And knowing that his nurse had understood his predicament, his sense of isolation and alienation had now been overcome. He was now more willing to co-operate, to be a more willing member of the corps.

Excerpts from Dickson's poem (as cited in Jonas-Simpson, 2001) offer us a poignant description of how Philip (or, for that matter, my own patient Bob, whom I introduced earlier!) might have felt having been understood:

> Feeling understood is a change of season . . . relief that melts tension, lightens desperation, eases anxiety. Confusion quiets, struggle subsides. Frenzy is replaced with timeless calm. . . . Isolation dissolves into cozy communion, an intimate emotional bonding. Boundaries soften. I and thou are warmly united.

> Feeling the understanding acceptance, soaking in supportive attention, I am recognized, validated, honored. . . . Poised and confident, new strength races through me. Fuelled and empowered, I move forth assuredly, . . . authentically expressing my being. Defenses dissipate, anxiety lowers. (p. 227)

As we see in Philip's situation (as well as in Bob's!), "understanding alone was a great gift" (Benner & Wrubel, 1989, p. 11). However, more often than not, understanding of the patient's subjective experience, mediated through presence, provides the ground from which other responsive nursing actions and interactions can emerge. Given that such actions and interactions are based on the particularities of the patient's unique situation, they are also more genuinely human. A critical care nurse alluded to this when she said:

> *You can make a difference for the patient when you take into account what they are experiencing and perhaps what it means to them. So I try to get as close as I can.*

Later, this same critical care nurse described how she uses what Cameron (2002, 2004) refers to as the ultimate gesture of presence—the authentic nursing "How are you?"—to gain an understanding of her critically ill patient's subjective experience:

> *You know, when somebody says, "How are you?" and the words aren't even out of their mouth and they're on to something else, I think it's so insincere. I don't ever want to come across like that to somebody, and especially somebody who's been thrown into a traumatized state. When I sit down with somebody and say, "Tell me what's going on" or "Tell me how you feel," I actually sit and I make eye contact and I'm almost in their space because I want them to know that I want them to talk to me. I'm not there to pat them on the head and say, "Everything will be okay." I truly want to know how they are! That's the only way I'll get to the actual issues.*

The authentic "How are you?" of this nurse is not just a mere gesture of greeting offered in passing. Rather, it is a genuine question for which she wholeheartedly, patiently, and silently awaits the answer. She wants to "*hear their stories.*" She wants to "*find out where they are coming from.*" She wants to hear, to know, to appreciate, and to receive who they are and what they are experiencing (Burkhardt & Nagai-Jacobson, 2002). She does not use empty words that silence, but rather she uses silence to listen for the meaning that fills their words. She perhaps expects too that by silently listening she will also hear the silent messages encoded in the words (or in some cases, in spite of the words). These messages she too needs to hear if she is to respond to the subjective experience of the critically ill in a responsive, sensitive, and humanizing way.

Yet what about the many critically ill who are mute or for some other reason unable to vocalize their thoughts and feelings? Do such circumstances preclude understanding? The story about Bob suggests that they do not, but rather, that it is possible to achieve understanding in such circumstances. How then is it possible to understand the experience of others who are unable to express themselves verbally? van Manen (1991) helps us understand by suggesting that, given a "capacity for trustful sympathy" (p. 97), it is often possible for critical care nurses to have an immediate grasp or an engaged understanding of what is going on with their critically ill patients. To have a sympathic capacity means that one is able to discern the inner thoughts, understandings, feelings, and desires of another from indirect cues such as gesture, demeanor, expression, and body language (van Manen, 1991). Sympathically, one is able to sense (feel) what another is experiencing or what mood the other is in and, based on that understanding, sense the right thing to say or do (van Manen, 1991).

> *One day I sensed that Bob was having a rough time; I just knew. I could feel the tension. He was experiencing a lot of pent-up frustration. Just before leaving I bent over and said, "Bob, when I go for coffee, . . . I'll scream for you."*

In my encounter with Bob (Hawley, 2000a), I sensed not only his extreme frustration, but also his need to express his feelings. Normally when we are angry or deeply frustrated and need to express our feelings, we may do so physically—by throwing an object, slamming a door, kicking a chair, hammering a fist, and so on. Or we may resort to expressing ourselves verbally—by lashing out, swearing, crying, shouting, or moaning. But Bob could do none of these. He could not move. Nor could he talk. And even if he could have talked, would words have been enough to express his suffering predicament? Given Bob's tormented existence of being bodily trapped—entrapped as a body and entrapped in a body—I sensed not. Like others who are tormented or desperate, I sensed his desire to scream—a primordial mode of expression of utter desperation and deep frustration. In offering to scream for him, I validated (acknowledged) his experience, and with that validation he knew that he had been understood. He now had the will to continue his battle.

By way of other examples in which the expressiveness of one is recognized by another, you may recall feeling the sadness of a tearful or grief-stricken face. Or, indeed, you may have felt the happiness of another's smile. Similarly, you are no doubt familiar with the expression "the eyes are the window to the soul." Like many a critical care nurse, those of you who have seen and interpreted the eyes of fear know that the eyes can speak volumes without solicitation—instantly, adequately, and accurately. Likewise, through knowing eyes, soothing talk, kind gestures, or gentle touch, one can convey that one has seen and interpreted the soul of the other (van Manen, 1991), that one acknowledges the subjectivity of the other and has understood the other's subjective experience.

As I have previously suggested, acknowledgement and understanding of another's experience are facilitated by sympathy and require one's engagement, involvement, or presence. Critical care nurses express this notion of having achieved intersubjectivity in phrases such as "*We bonded*" or "*We really clicked,*" the latter being a rather apt description given that a "click" is the sound we hear when a connection is made. Thus, in establishing a relation of intersubjectivity, a sense of connectedness—an existential bond—is created whereby one can sympathically enter into and understand the experience of the other (Leder, 1990). As Gadamer (1989) says, "The ultimate grounding of all understanding . . . depends on a pre-existing bond between all individuals" (p. 189).

To have sympathy—derived from the Greek *sumpátheia*, which means 'fellow feeling' (Onions, 1966)—is to feel the other's feeling (Scheler, 1912/1970). However, as Scheler points out, this feeling the other's feeling is not the same as going through the experience itself. Rather, it means that one feels something of the other's experience or has incorporated enough of the experience to awaken an echo of the same experience within oneself (Leder, 1990). With a mutual sense of resonance awakened, one now recognizes the experience of the other as a possible experience of oneself (van Manen, 1991). For example, how often the following sentiments were expressed by critical care nurses when they told their stories about their critically ill patients' experiences: *"I could really relate"* or "*It really struck a nerve with me.*" And how frequently the recognition of these experiences, as possible experiences for themselves or their own family members, became the basis for responding in a responsive, sensitive, and humanizing way. As critical care nurses shared their stories about making a difference, they often justified their actions and interactions on the basis of what they would want said to, or done for, them under similar circumstances. As expressed succinctly by Olson (1993), "The abiding 'as if' is a condition for nursing care" (p. 148).

This abiding "as if" is often at the heart of the "*little things,*" the "*simple things*" that nurses do to make a humanizing difference in the experience of critical illness and critical care. Like van den Berg (1966), critical care nurses in their wisdom have also come to know illness as the giver of little things. As van den Berg explains:

> The healthy person is usually so much occupied by important matters of career, learning, esteem, and money that he is inclined to forget the little things. Yet at closer inspection he has to admit that it is never these matters which mark his life. . . . The sick person acquires a new sense of these little things. . . . In a very special sense they do become trusted or even dear to him. (pp. 68-70)

Whether it is accommodating a sweet-grass ceremony, allowing a special visitor (e.g., the newly born grandchild, the family pet, or the just-married couple), honoring a nap routine, reading a story, playing some music, turning on a hockey game, having a game of cards, celebrating an engagement, remembering a birthday, making a follow-up visit after transfer, bearing the gift of a flower plucked from the hospital garden or a souvenir baseball cap from a recent trip, arranging a Christmas haircut, displaying a picture, or spending a little extra unsolicited time grooming or "*pampering*" with makeup and nail polish, or just "*kibitzing,*" and so on, these "*little things,*" "*simple things*" all arise from the critical care nurse's understanding of the patient's situation. They are grounded in the presence and engaged understanding of the critical care nurse and, in realizing the absolute dignity of the golden rule (Eriksson, 1997), all serve to reinforce a critically ill patient's sense of integrity, wholeness, and value as a human person (Younger, 1995).

Revealing Human-ness

Regarding the patient as a "whole" would seem to require nothing less than the nurse acting as a whole person. Therefore, the person who withdraws parts of the self is unlikely to allow the patient to emerge as a whole, or to comprehend that wholeness if it does emerge. (Gadow, 1980, p. 87)

The notion that a critical care nurse's acknowledgement of the human-ness of a critically ill patient involves the human-ness of the critical care nurse is not novel. Earlier I proposed that, for a critical care nurse to respond sensitively to a critically ill patient as a vulnerable human person (as a subject and not a mere object), a primordial relation of intersubjectivity, an engaged relation, must be established. As this relation presupposes the subjective involvement or the presence of the critical care nurse, it is assumed that aspects of the self (the human person) of the nurse are involved. Indeed, the "abiding 'as if' " (Olson, 1993, p. 148) as a condition of nursing care described above attests to the involvement of the subjective self of the nurse, albeit indirectly, and shows how, for example, sympathic involvement leads to actions and interactions that make a humanizing difference in the patient's experience of critical illness.

Additionally, however, several critical care nurses claim that humanizing differences are also made when the individuality of the human person of the nurse is directly revealed to, rather than concealed from, patients. In particular, they perceive the value that inheres in the immediate sharing or expression of the more personal aspects of the subjective self of the nurse (the "*human side*" of the nurse) with patients rather than always maintaining the "white crispness of professionalism" (Pettigrew, 1990, p. 505), which they characterized as being "*distant,*" "*detached,*" "*impersonal,*" "*serious,*" "*sterile,*" "*rigid,*" or "*cold.*" The remarks of critical care nurses below are indicative of their sentiments:

> *I think you get further if you let your human side out more often, instead of always being staid and prim and proper.*
>
> *Always being very professional is really sterile and removed from the patient. . . . Focusing on things beyond the illness lets them [the critically ill] be whole people.*

Hence, not unexpectedly given the mutuality in the nurse-patient relation, the human-ness of the critical care nurse is just as important as the human-ness of the critically ill patient when it comes to humanizing the experience of critical illness. In other words, to be able to perceive the nurse as a unique human person like himself or herself (and not just simply a "*robot*" or instrument that treats disease) is just as humanizing for the patient as is the patient being acknowledged and treated as a unique human person by the nurse.

In light of the above comments, many critical care nurses would no doubt agree that some of their most momentous differences arise when their self-protective shield or “character armour” (Jourard, 1971, p. 180), in the guise of professionalism, is removed and they more fully manifest their true selves. And in all likelihood, this is also an important premise underlying Gadow’s (1980) proposal that the entire self of the nurse be engaged with the patient because, in her view, every dimension of the person of the nurse, including the nurse’s feelings, values, and idiosyncrasies, is a potential resource in the delivery of care. She remarks:

> Nursing care, because of its immediacy, sustained, and often intimate nature, as well as its scientific and ethical complexity, offers ready avenues for every dimension of the professional [e.g., the nurse] to be engaged, including the emotional, rational, esthetic, intuitive, physical, and philosophical. (p. 91)

Yet one wonders how critical care nurses manifest their human-ness (their human side) to their critically ill patients. What aspects of their human-ness do they reveal? How do the critically ill experience this revelation? What difference does this revelation make in patients’ experiences of critical illness?

One of the key avenues through which critical care nurses reveal their human-ness to patients is by engaging in social conversation, often sharing their unique interests and life experiences as well as those they have in common with their critically ill patients. Just as in ordinary, everyday life, children or grandchildren, pets, sports, music, entertainment, and hobbies are popular topics. Whereas the so-called professional behavior of avoiding any type of personal interaction or disclosure serves to distance patients and nurses from each other, this sharing of nurses’ selves in social conversation serves to bridge that distance and affords an opportunity to enhance patients' trust, improve communication, and, ultimately, strengthen the human bond between them.

So too, as you well know from having established relationships in your personal lives, sharing invites sharing. Likewise, the sharing of the self of the nurse in the professional (nurse-patient) relationship often prompts more self-disclosure on the part of the patient, often providing the nurse with a "*little extra information that can make the nursing more meaningful, where the care goes from routine to personal*"; that is, where the care is individualized rather than standardized and thus more responsive and sensitive to the patient's uniqueness as a human person. And as one critical care nurse stated, "*Care that recognizes what is important to people shows them that they are important.*"

Critical care nurses also reveal themselves as human persons by allowing their idiosyncrasies and human imperfections to exude their nursing activities. The anecdote in which Gordy's nurse described her klutzy behavior provides a good example. By just being her usual self, muttering away, dropping and spilling things, and tripping, it is apparent that, given Gordy's infectious grin in response, she lightened a moment during an otherwise very somber time in his life. In exposing her foibles, she most likely also counteracted the intimidating atmosphere of the critical care unit that he had no doubt endured during most of his long, dark sojourn. Perhaps his discovery that she too was human (and therefore "*fallible*") fundamentally changed a perceived power imbalance between them. If so, sensing that he had been spared the trepidation of someone overpowering—with power over him—he may have felt more self-confident, more self-assured, more courageous, and less threatened. He may have felt that he too could now drop his self-protective shield—that he too could now reveal his human side.

And last, but by no means least, critical care nurses reveal themselves as human persons by openly expressing their emotions. For example, as they told their stories and recalled their experiences, many critical care nurses admitted to crying with their patients or in the presence of their patients or their families. They cried in times of sorrow; for example, in response to a patient's death, dying, or other horrific situation. They also cried in times of joy; for example, in response to hearing a long-term trached patient who had been gravely ill talk for the first time, or in seeing a patient who had unexpectedly survived return to the unit for a social visit. And although some critical care nurses thought that such emotional expression, particularly in times of sadness, contravened conventional wisdom, they themselves considered such behavior to be appropriate and beneficial in some way. As one critical care nurse declared:

> *Even though it's not recommended, I think that to be seen with a tear in your eye is as important as laughter. If your ability to empathize . . . brings a tear to your eye, so be it. I don't think you should be ashamed or fearful of that. If you can't, or you don't recognize someone's sadness or whatever, I think it's time you left [nursing] and went elsewhere . . . . Because you can't NOT feel!*

Similarly, another expressed that "*sometimes letting families see your emotions come through can be a small gift you give them.*" Yet one wonders what this gift could be. Is it perhaps the gift of one's presence wrapped in "*compassion*"*?*

The word compassion abounds in the everyday vocabulary of nurses and in the nursing literature (Burkhardt & Nagai-Jacobson, 2002; Charon, 1996; Cooper, 2001; Roach, 2002). If you were to ask a nurse to tell you what qualities he or she thinks a nurse should possess, undoubtedly compassion would be among the forthwith responses. However, despite such common usage of the term within nursing, what does compassion mean? Or what does it mean to be compassionate? The word is derived from the Latin *cum* and *patior*, which together mean 'to suffer with' (Onions, 1966). And indeed, in our ordinary use of the term, we typically speak of extending compassion to someone who is suffering. Yet as Leder (1990) indicates, the Latin notion of *patior* is not used solely in reference to pain and misfortune, but rather, more broadly, it means "to suffer something to happen"; that is, to undergo an experience

(p. 161). In using the word in this sense, compassion is a general term that refers to an experiencing-with another, as in sharing another's experience; for example, another's sorrow or another's joy (Leder, 1990). Accordingly, the meaning of compassion is closely associated with the meaning of sympathy, as described earlier. It therefore comes as no surprise that, in the *Oxford Dictionary of English Etymology* (Onions, 1966), the term fellow feeling is a descriptor for both compassion and sympathy. And although compassion is the term most frequently used by nurses, it is now apparent that the terms compassion and sympathy can be used interchangeably.

Semantics aside for the moment, however, it is the notion of sharing another's particular human experience that is of real importance here. And whether it is sharing joy or sorrow, the bodily expression of nurses' emotions in response to these shared experiences with patients is considered to be a natural and therefore a "human" thing to do; it is an authentic expression of one's human-ness or, as nurses describe it, an expression of one's "*human side.*" Therefore, critically ill patients who are witness to such expressiveness in their nurses come to realize that their nurses are human too and thus share their human vulnerabilities. And in recognizing this mutual vulnerability, along with their shared human frailties, as mentioned above, critically ill patients may come to an even deeper awareness that critical care nurses are not so powerful or full of power, but rather that these nurses are in "power-with" (Daniel, 1998, p. 191)—in solidarity with—them. And given the authenticity that inheres in nurses' expressiveness, the critically ill who witness such authentic expression of emotion will no doubt sense (feel) the continued presence and engaged understanding thus revealed by their nurses; a revelation that may serve to reaffirm their dignity and, consequently, preserve the humanization of critically ill patients' experiences of critical illness.

Although his insights on compassion are solely in reference to suffering, it is Henri Nouwen (as cited in Roach, 2002), a theologian, who probably best and most succinctly captures the sentiments about compassion in critical care nursing practice as interpretively described above. As such, his reflections merit inclusion:

> Compassion involves us in going where it hurts, to enter into the places of pain, to share in brokenness, fear, confusion, and anguish. Compassion challenges us to cry out with those in misery, to mourn with those who are lonely, to weep with those in tears. Compassion requires us to be weak with the weak, vulnerable with the vulnerable, and powerless with the powerless. Compassion means full immersion in the condition of being human. (p. 50)

Guarding Against Indignity

"Of all the professionals, nurses perform the most intensely personal services for all people in extraordinarily vulnerable positions. Occasionally we hold a person's life in our hands; almost always his [or her] dignity" (Curtin; as cited in Heron, 1994, p. 279).

I have previously emphasized respect for another's dignity as a means of humanizing the experience of critical illness. However, respect for another's dignity as it is specifically achieved through respect for another's privacy has yet to receive the attention it is due. In relation to the notion of making a humanizing difference in the experience of critical illness, the comments of several critical care nurses reflect an existing common ideology that, despite the need to access all parts of critically ill patients' bodies while providing critical care, critically ill patients still deserve to have their privacy respected to the extent possible. Accordingly, denial of this respect for privacy is regarded as an indignity and is thus de-humanizing. Yet one might wonder just how respect for another's privacy confers respect for another's dignity or, conversely, how disrespect for another's privacy constitutes an indignity. And given the circumstances surrounding critical illness and its associated care, how do critical care nurses actualize this ideology of respect for the privacy of the critically ill in their everyday practice? Or if in situations where actualization of this ideology of respect for privacy is not possible, are there ways to counteract the experience of indignity?

As previously described, the body in its ordinary (healthy) state is experienced in a silent or taken-for-granted manner. However, when one is confronted with critical illness, this taken-for-granted experience of the body is disturbed. The object-like nature of the physical body is discovered and not easily forgotten. And as the object physical (objectified) body dominates one's existence, one's dignity is violated, and thus we speak of the indignity (de-humanization) of illness.

Similarly, in ordinary, everyday societal life there are taken-for-granted rules about the body (Lawler, 1993). In the event of critical illness, however, many of these taken-for-granted rules are necessarily violated as critical care nurses must intimately care for the bodies of the critically ill, potentially creating, yet again, situations in which the physical body as object becomes a dominant theme in one's existence, thus violating one's dignity. Therefore, with some qualification, we can also speak of the indignity (de-humanization) associated with body care in critical illness. And it is this source of indignity, or perhaps more aptly stated, the prevention (or management) of this source of indignity, that will be a focus within this subsuming theme of "guarding against indignity."

As Lawler (1993) informs us, the privatization of certain body parts (e.g., the genitals and other body parts associated with sexuality) and body functions (e.g., elimination, bathing, and sexuality and sexual behavior) associated with civilization necessitated rules (now taken for granted) specific to body access and touchability, body exposure, acceptable bodily related topics for discussion, and sexuality and sexual behavior. For example, there are taken-for-granted-rules on where, how, and when to touch the body, with touching of some body parts heavily proscribed.

However, as mentioned, the nature of critical illness and its associated care are such that many of these taken-for-granted rules (e.g., rules concerning the privacy of the body) must necessarily be broken. For example, the intrusion into personal space, the exposure and touching of private body parts, the procedural invasion of body boundaries, and varying degrees of assistance with and probing discussion about ordinarily private bodily functions are often required during the process of caring for the diseased and injured bodies of the critically ill. And while critical illness and its associated care may be one circumstance in which it is more socially acceptable to violate these taken-for-granted rules, there are still strict taken-for-granted rules that apply. If broken, they place the physical body as object into greater prominence, with obvious potential ramifications. Violation of these applicable rules is considered to be an indignity and, with few exceptions (e.g., situations of extreme immediacy or unconsciousness where the indignity may not be felt), a source of embarrassment, awkwardness, self-consciousness, or humiliation for the critically ill. Indeed, one may also agree with Lawler (1993), who contends that failure to even recognize the potential ramifications prior to such violation reduces the critically ill patient to an object and in and of itself constitutes an indignity.

In response to the earlier question on how critical care nurses actualize the ideology of respect for the privacy of critically ill patients, avoidance of overexposure or unnecessary exposure of the body and reduction of the audience are considered fundamental. A critical care nurse explains using the bed bath as an example:

> *I always provide as much coverage as possible. I close the curtains and warn others of my plans so they don't come barging in, in the middle.*

If you recall from the story told by the nurse who cared for Mrs. Buckley as she was dying, there is even a "dignifying way" to change the blankets. Although I am uncertain whether or not Mrs. Buckley experienced this "*small*" gesture, the gratitude that her husband expressed certainly provides testimony to the sense of reverence that he experienced through the respect for privacy the nurse extended to his wife.

In situations that pose a challenge to maintaining body coverage (e.g., traction), nurses also "*try makeshift-type things.*" As one critical care nurse explained:

> *I've pulled the sheets up and over the side rails and held them in place with Kelly forceps. And I've found that pillowcases make wonderful modesty blankets for the pelvic area, particularly for the men. So you sometimes have to be creative. You do the best you can.*

Critical care nurses have also commented in passing that they ask family, visitors, or others to leave the room for procedures and conversations deemed private. And depending on the status of the patient and the context of the situation, the critical care nurse may even ensure that the patient has at least some visual privacy from the nurse while he or she independently performs activities associated with ordinarily private body functions. For example, the nurse may stand outside a drawn curtain or step just outside the door until permission to reenter is granted, often either in response to a verbally expressed "*Knock, knock*" through the curtain or as the nurse literally knocks on the door.

Although it is perhaps self-evident, it is also noteworthy that conformity to the taken-for-granted rules about body privacy (e.g., private bodily function) is also influenced by one's own ability to conform to these rules which, in turn, is influenced by the degree of control that one has over one's body. In its healthy state the body is obedient and thus within one's control. Accordingly, conformity (or lack of conformity) to the rules about body privacy is essentially a non-issue.

However, because of various pathophysiological processes associated with critical illness or in response to various treatment modalities associated with critical care, one's body may be beyond control and thus place itself in violation of these taken-for-granted rules. The body may respond in unusual or unexpected ways or simply object to doing in the usual or expected ways, creating, yet again, instances in which the body announces itself as object and becoming a source of indignity. And in addition to embarrassment and frustration, an indignity that is likely also to result in feelings of shame from self-accusation and self-condemnation.

Of particular relevance here is the indignity associated with unintended bodily acts such as incontinence, diarrhea, or vomiting and those bodily acts unintentionally made public such as crying, burping, and flatulence. Given the uncontrollable nature of one's body in situations such as those just described, prevention of these privacy violations as well as their ramifications is difficult. Of relevance also is the fact that some degree of loss of bodily control (e.g., paralysis, weakness) also underlies critically ill patients' dependence on others for basic body care (e.g., bathing and grooming) whereas most likely at some time previously, this ability to do by one's self was taken for granted. Thus this state of dependency in and of itself constitutes a potential indignity. Moreover, "to add insult to injury," so to speak, a further indignity is often imposed when nurses remove those aids or prostheses that have become extensions of their patients' bodies (i.e., embodied); for example, when they "*take off their glasses and take out their teeth.*"

Although tangential to aspects of privacy, another potential source of indignity relevant to bodily control, and thus appropriate for comment here, is that precipitated by such actions as sedation and physical restraint that impose bodily control on the critically ill, particularly if used inappropriately, unnecessarily, and without the accompaniment of "engaging" interaction. One need only recall the anecdote about Mrs. Smith who had been "*hurt by the ordeal*" of having been needlessly sedated and restrained on two occasions following neurosurgery to evacuate a subdural hematoma. Many would no doubt agree that her feelings of anger and humiliation in response to this enforced control were appropriate under the circumstances. And given the myths about and extensive disregard for persons with mental illness in our society, her comment about being treated like someone "*on a psychiatric ward*" was unlikely happenstance. Therefore it would not be too farfetched to question whether or not similar thoughts ran through the mind of Echo Heron's (1987) patient as he angrily struggled to free himself from the restraints securely tied to the side rails following his resuscitation. Nor would it likely be too outlandish to intimate that, as he struggled to free himself from the tethers, he may indeed have felt like a prisoner of war.

In reference to the use of sedation and restraint in the critically ill, particularly the critically ill elderly, one nurse informingly had this to say:

> *I've seen a change in mentality in the unit over my years. It's now become a recovery-room sort of mentality, I think. Lots of sedating. Older people don't sleep at night, not all of them anyway. But they shouldn't be sedated or tied up, particularly if they're your only assignment. Just because they're in the unit, you can't command them to sleep at night, and giving them drugs just makes them more confused. And if you're not mobilizing them on top of that and you're tying them up because they are getting confused, it becomes a vicious circle. And so you keep throwing more fuel on the fire. And there is a real person there! It could be somebody's grandma or grandpa. It's NOT FAIR!*
>
> *I use hardly any sedation. A lot of the time I just hold their hand or spend time at their bedside. If you leave their hands untied, they're better. I would hate to be tied; it is such a violation. If I were tied up, oh man, I'm sure you'd have to paralyze me! It's so degrading. And some people get their hands and feet tied up! I don't think there's any reason for it!*
>
> *If you sit and just spend the extra few minutes sitting there, explaining things—I give them three chances. You actually have to be there at the bedside, not socializing or playing on the Internet. You have to actually be there so you can jump 12 buildings in a single bound if you have to. Just give them some time and see if you can trust them. And I haven't had any extra extubations, or more than usual, or whatever.*

While sedation or physical restraint, or both, are often the first responses of many critical care nurses to states of confusion and restlessness among the critically ill, such actions are a last resort for this nurse. She too is concerned about patient safety (e.g., patients extubating themselves and pulling out their lines) in these circumstances, but she realizes that something else is at stake here—respect for the dignity of her patients. In addition to her sympathic awareness of the indignity associated with the use of sedation and restraint in the critically ill, she is also aware that such measures do little to resolve the underlying problems. Instead, they often compound them, in turn rendering patients increasingly defenseless and vulnerable in the process. She sees no good reason to intensify their already terrorized state with the torture of being tied and tethered. In her experiential wisdom, she knows the difference that the more "humane" measures can make. Not only are they just as safe as the "inhumane" alternatives, but they are also the ones that will most likely help guide patients out of their entanglement and bewilderment.

Finally, there is the potential indignity precipitated by the conspicuous body (Bleeker & Mulderij, 1992; van Manen, 1998). The bodies of the critically ill may be conspicuous because of bodily changes such as disfigurement, deformity, or mutilation as a result of disease, injury, or treatment. Or there may be body products (e.g., urine, feces, sputum, emesis, mucus, or drainage) that are conspicuous by virtue of the fact that, in addition to being publicly visible, they are often aesthetically unpleasant in appearance, odor, or both. Whatever it is that makes one's body conspicuous competes with one's subjectivity for the attention of the other, often resulting in a look such as a curious stare that objectifies the body or in the objectifying experience of being looked at with disgust, distaste, or disapproval. And as in other situations that place the object physical body in prominence, the conspicuous body too becomes a potential source of indignity resulting in the aforementioned negative feelings of embarrassment, awkwardness, self-consciousness, or humiliation.

Yet despite the sources of indignity described above, the experiential accounts of critical care nurses reveal that they make a humanizing difference in these situations. Through their actions and interactions, critical care nurses are able to counteract these experiences of indignity in ways that are contextually appropriate and as diverse as their contexts. They may deliberately understate the situation to the patient as they clean up after an episode of explosive diarrhea caused by tube feedings. They may take a "matter-of-fact" (Gramling, 2004, p. 392) or "business as usual" (Lawler, 1993, p. 158) approach with the patient when they deliver an enema or cleanse a new colostomy. They may hide a horribly infected wound from the patient. Or they may teasingly warn a male patient about the dangers of a urinary drainage catheter being accidentally pulled. As Lawler points out, there is great variability in the strategies nurses use; "it depends on the patient" and "it depends on the situation" (p. 156). However, as alluded to earlier, a humanizing strategy never precludes the possibility of a response that appropriately reflects the critical care nurse's engaged understanding of a critically ill patient's difficult situation.

The encounter described by the nurse who cared for Freeman, the patient who was found unconscious in a boarding house and required emergency neurosurgery, exemplifies one such situation in which a nurse manages to deter an experience of indignity by responding in a manner that reflects an attunement to, and genuine concern for, the patient's predicament. Given the bodily state in which Freeman was reportedly found, this nurse knew that his post-op bath was not going to be an ordinary or typical one. Alerted by the ER staff that "*his state of hygiene left much to be desired,*" she more than likely anticipated that this particular bath would be aesthetically difficult. However, her account reveals no hint that any such experience was affectively communicated to her patient. She no doubt sensed that to respond otherwise would have been a source of embarrassment to him (Lawler, 1993). Yet despite her appropriate lack of affect in this regard, she remained sensitively engaged and sympathically attentive to her patient's subjective experience as she respectfully handled his soiled and deceptive body. Indeed, if one considers the engaging manner of the nurse in this encounter, one may conclude that Freeman was treated with the utmost respect for his dignity (Gadow, 1980).

By taking her time, Freeman's nurse demonstrated her commitment. She was there just for him in this moment (Cameron, 1998). With her gentle touch, she helped him feel his worth. And although the details of her explanation to him about his catastrophic situation are unknown, it seems plausible to suggest that she created a more permissible atmosphere (Lawler, 1993). For example, by defining his predicament as one that he could not have avoided, she would have made his loss of bodily control and current state of dependence more acceptable to him. By absolving him of blame, she would have protected him from feelings of shame. Regardless of the details of her explanation, however, one can be certain that, given the gratitude that he expressed from deep within his soul, she did indeed deal with the overall situation in a thoughtful and tactful way (van Manen, 1991).

Combating the Technological Imperative

"Sometimes even challenging the status quo can dim the blinding light of technologic promise and illuminate the human values that are so often left in the shadows" (Drought & Liaschenko, 1995, p. 303).

> *There are zillions of things that modern technology can do, but that doesn't mean that we have a right to do them. The sad thing is that there is too much technology available nowadays, and we have a lot of physicians who feel that it's their responsibility to utilize every little bit of technology that's there, regardless of the consequences.*

The above comments from the critical care nurse who shared the anecdote about Ann Marie, the young severely mentally challenged woman who underwent a lifesaving liver transplant and subsequently fell victim to "*every complication in the book*" before the plea to allow her to die with "*some dignity*" was finally heard, clearly attest to the technological imperative that prevails in the critical care units of today. As many physicians get "swept away" (Tisdale, 1986a, p. 429) by the latest and most powerful technological weapons against death, disease, or injury, there is often little regard for the consequences of such on their human targets. Yet as Gadow (1988) argues, when the battle intensifies suffering to the extent that it cannot be alleviated by care, the battle itself becomes morally questionable. Ann Marie's nurse shares a similar view. With conviction she remarked:

> *It was as if her [Ann Marie's] liver was to be saved at all cost, at the sacrifice of her. Yeah, her liver was still alive, but her body was dying. To me this was so morally and ethically wrong.*

Despite the many successes that technology has enabled, its pervasive use in critical care is not without risk of harm and human cost. There are times when what might be considered a technological triumph also represents a "lapse of humanity" (Frank, 1991, p. 27); for example, when the critically ill are saved from death only to be consigned to an unliveable life or when their lives are dragged out at all costs and "they die in anguish, with too much technology" (Olson, 1993, p. 175).

The six-month torture that Ann Marie endured consequential to the unrelenting transplant service and the complications of her liver transplant is but one example of this "lapse of humanity" (Frank, 1991, p. 27). Although, as Ann Marie's nurse intimates, the transplant service may have addressed their own discomfort with the "public wringing of hands called . . . ethics" (Tisdale, 1986a, p. 430), Ann Marie's situation resembles others in which critical care nurses are left morally uncomfortable about the decisions that have been made and particularly among the less experienced and less confident, in a "*quandary*" over "truth telling" (Gadow, 1985, p. 37) despite their overall commitment to an "ethic for disclosure to patients and families" (Benner et al., 1996, p. 16).

Whereas the inhumanity initially associated with Ann Marie's situation is readily apparent in her nurse's account, the more subtle experience of de-humanization that perhaps helped pave the way to this inhumanity is less obvious. Like countless other critically ill patients who are "silent" (Gadow, 1989, p. 535), or perhaps "silenced," Ann Marie's subjectivity was not given voice—at least, not prior to this nurse's involvement. Just like the critically ill patient with the multiple emboli to whom I referred earlier, her right to self-determination had not been given a thought. And along with many other critically ill patients, like Echo Heron's (1987) patient, for example, whose previously voiced wishes were disregarded, ignored, unheeded, her exercise of autonomy had ultimately been denied. And while decisions about the care of her body were being made solely on the basis of objective viewpoints, she too was reduced to object status and thus de-humanized.

Ann Marie's situation is not uncommon, atypical, or rare. In their experiential accounts, critical care nurses attested to the prolonged suffering (and dying) that many critically ill patients experience at the hands of technology that has been indiscriminately and inappropriately used (Drought & Liaschenko, 1995). As they bear witness to suffering at the bedside of their patients, many critical care nurses have astonishingly wondered:

> *When are we gonna stop? Where's the humanity? Where's the compassion for this person? This is a human being.*

Yet the experiences and stories of these nurses also reveals their capacity to make a humanizing difference in their patients' experiences of critical illness by actively pursuing that sense of "*humanity*" (as in humaneness) for their patients that others may only ponder, if they think about it at all. With respect to technology-supported care, that sense of humanity is often achieved when critical care nurses successfully combat the technological imperative. Accordingly, their motto in this pursuit, "Just because we can does not necessarily imply that we should," comes as no surprise!

By campaigning for the prudent use of technology, critical care nurses are often able to thwart the needless suffering of patients that is frequently precipitated by the automatic and unquestioned use of this technology. As the following remarks by Ann Marie's nurse suggest, critical care nurses can make a difference when they advocate for their critically ill patients and not the technology!

> *I make sure that I confront them [the physicians] by asking if the [proposed treatment] is for the sake of entertainment, or is it really going to make a difference? It takes confidence to "talk back," but I find that's a way I can make a difference. I am comfortable with that skill.*

By establishing a relation of intersubjectivity, critical care nurses are in a key position to "*speak out,*" "*stand up,*" or "*fight*" on behalf of their patients, particularly those who are unconscious or for some other reason unable to verbally communicate their wishes or defend previously expressed directives. Because of their involvement over time, they develop an extraordinary ability to sense from the patient's perspective where the boundary between harm and benefit lies (Gadow, 1989). And it is this engaged knowing, formally described as "clinical phronesis" (Schultz & Carnevale, 1996, p. 189), that enables critical care nurses to speak, not with their own voices, but rather, to the extent possible, with the voice of the patient and in so doing truly fulfill their moral responsibility to foster patient autonomy—the hallmark of true advocacy (Gadow, 1989) and another truly humanizing process.

Like Ann Marie's nurse, many critical care nurses have reportedly challenged physicians regarding their decisions involving technology, "*called them to account*" for their planned actions, or, as a last resort, "pulled rank" and blatantly refused to carry out orders that they "*just knew*" would do more harm than good. As the saying goes, sometimes "actions speak louder than words." And as critical care nurses have very courageously "*gone out on a limb*" or "*gone to bat for*" the sake of their patients, they have placed themselves at risk while protecting their patients from risk. Is this another paradox of this place of battle? Perhaps. Is this a testament of their commitment to their critically ill patients? Certainly. What difference does it make in patients' experiences of critical illness? A significant difference.

As a result of critical care nurses who have undertaken a critical stance toward the use of technology and have victoriously challenged the status quo (Drought & Liaschenko, 1995), treatment priorities have often been reestablished, with the immediate subjective experience of the patient taking precedence over measures that offer no "cure" benefit (i.e., do nothing to reverse the principal pathology or prognosis; Gadow, 1989). Thus, many critically ill patients have been saved from the angst of another torturous device, spared the anguish of another invasive procedure, or, for those such as Ann Marie who have succumbed to battle fatigue, peacefully "*sent home*" with their integrity preserved. As the famous passage from Ecclesiastes 3:1-8 (as cited in Nolan, 1992) states: "There is a time . . . for dying" (p. 90). Ann Marie's nurse sympathically felt that her patient's time had come and her knowledge of this momentous matter she could not justifiably withhold or ignore.

Making the Unbearable Bearable

> While the nurse may not be able to change the progression of the disease (or its treatment), the nurse helps to ease the dis-ease (Olson, 1993).

Despite the successful efforts of critical care nurses to avert needless suffering in their patients, the experience of critical illness and its associated diagnosis and treatment realistically and inevitably entails some measure of suffering. Indeed, the very word "patient", derived from the Latin word *pati*, means 'to suffer' (Onions, 1966). Paradoxically, additional suffering is often incurred, albeit inadvertently, as the alleviation of suffering in critically ill patients is pursued (Cassell, 1991). As alluded to previously, the critically ill commonly suffer as much from the diagnostic and treatment activities associated with their life-threatening diseases or injuries as they do from the underlying symptoms themselves. However, to better grasp this notion, we must first ask ourselves, What is suffering, and how is it evoked?

In the minds of most, suffering is closely identified with pain (as in bodily pain). In fact, the word "suffering" is usually coupled with the word "pain" as in the expression "pain and suffering." Yet as Cassell (1991, 1992) explains, pain and suffering are phenomenologically distinct. He defines suffering as a "state of distress induced by the threat of the loss of intactness or the disintegration of a person from whatever cause" (p. 3). Although suffering is often evoked by bodily pain, it is an experience of the whole human person: "Bodies do not suffer, persons do" (p. 3).

Although bodily pain remains a major source of suffering, it is only one among many, including those that lie beyond the physical domain (e.g., within the social, psychological, and spiritual dimensions of the human person). Hence, it is possible for someone to experience suffering in the absence of bodily pain. Moreover, it is also possible that bodily pain may not evoke suffering (e.g., the pain of childbirth; Cassell, 1991). And thus, in a manner of speaking it is possible to say, "We can have one without the other."

According to Cassell (1991, 1992), one's experience of suffering is contingent on the personal meaning (i.e., the significance and importance) that one ascribes to the pain, incident, encounter, situation, or event. However, although meaning and thus suffering are personal matters, the sources of suffering, and perhaps even their meaning, may be shared by others or by society as a whole (Cassell, 1991, 1992).

The word suffer originates from the Middle English *suffre*, *soffre*, and *soeffre*, which mean 'to tolerate,' 'to bear,' or 'to endure.' It derives from the Latin *sufferre*, formed from *suf* (up) and *ferre* (bear), which means 'to bear up' (Onions, 1966). Despite the archaic context of the word suffer, it is not uncommon in this day and age to broaden its original context and to describe suffering as an experience of "bearing a burden," perhaps in response to the occurrence of sudden, unexpected, and profound adversity in one's life or the need to take on, shoulder, or carry added responsibility.

Accordingly, we might say that the experience of critical illness, including the ordeal of diagnosis and treatment, brings its share of burdens for the critically ill to bear—burdens that may become too heavy to bear, too difficult to bear, or unbearable, particularly as they accumulate (Dewar & Morse, 1995). And while these burdens are many and varied, some are considered universal and inherently "burdensome" to bear. As such, they "bear" (as in hold) the potential to reach or exceed the limits of critically ill patients' endurance. Or, in other words, they are burdens that pose an ongoing (and potentially overwhelming) challenge to critically ill patients' ability to bear, to endure, to "*get through*" the unbearable aspects of the critical illness experience. Several of the burdens befitting this description are portrayed below.

Bodily pain, particularly that which is overwhelming, out of control, of unknown origin, seemingly endless, or has dire meaning (Cassell, 1991, 1992), is a torturous burden that many critically ill patients face. It arises not only from the pathophysiological processes that underlie life-threatening disease or injury (e.g., infection, infiltration, inflammation, or ischemia), but also from the physical assaults inflicted on the critically ill as their captive bodies are debrided, defibrillated, incised, instilled, intubated, manipulated, mobilized, pierced, poked, probed, punctured, stabbed, suctioned, and swabbed, and so on during the course of diagnosis and treatment. One need only imagine the painfulness of a body injured by burns, the painfulness of a burn wound undergoing a change of dressing, or the painfulness of an arterial line insertion. And not surprisingly, many critically ill are dreadfully burdened merely by the anticipation of recurrent pain or a recurring painful event. As Scarry (1985) reminds us, "What is 'remembered' in the body is well remembered" (p. 109). Bill's ordeal following his bilateral, below-the-knee amputation provides but one example of this commonly faced situation among the critically ill. His daily existence had become demarcated by painful dressing changes, with the time between them constituted by a sense of dread in anticipation of the next one.

In addition, other bodily dis-comforts, particularly those that share the same characteristics just described in relation to bodily pain, often pose a taxing burden with which many critically ill abide. Accordingly, the experience of (or, in some cases, the anticipation thereof) breathlessness, fever, chills, fatigue, nausea, vomiting, pruritus (itching), diarrhea, thirst, bloating, pressure, or other bodily dis-comforts may also contribute to the multitude of burdens associated with the experience of critical illness. Not surprisingly, just as in bodily pain, the burdensome nature of such bodily afflictions, and thus the experience of suffering, is often exacerbated by the concomitant existence of the formidable burden of fear.

Those who have witnessed patients in respiratory failure need only recall the fear evident in their eyes, facial expressions, and body gestures to appreciate the grueling, panicky, and terrifying nature of breathlessness. Their bodies speak of their intense suffering in a way that their speech literally and figuratively cannot do: Breathlessness begets speechlessness. For those who have not witnessed such suffering, the commonly used descriptive expressions such as "increased work of breathing," "air hunger," and "rest-less-ness" may provide some degree of insight, albeit indirectly, into the burdensome nature of their suffering plight. Essentially, there is "no rest for the respiratory distressed" as long as they must laboriously and anxiously employ all of their accessory muscles to breathe—to inspire air into suffocatingly stiff lungs that feel like lead, and to keep their oxygen-starving bodies fed.

In addition to the burden of fear that typically accompanies bodily afflictions, many critically ill patients also contend with this formidable burden as they encounter the alien, strange, and foreign territory of the critical care unit and the unfamiliar and uncertain events associated with the nature of the care that is provided. Similarly, they may also contend with the burden of fear as they worriedly wait for an indeterminate period of time for a diagnosis or prognosis that has yet to be determined. As alluded to earlier, many also brave the traumatic burdens of embarrassment, shame, or humiliation owing to the insensitivity, intrusion, and indignity that may be occasioned by a variety of providers during the delivery of care. And many withstand the onerous burden of alienation that is evoked by the isolating and lonely experience of critical illness itself (Cassell, 1991; Leder, 1990; Younger, 1995) and often accentuated by a lack of understanding, deception, nondisclosure, or the doling out of "shallow platitudes" (Clark, 1991, p. 261) and false reassurance on the part of others or, indeed, is self-perpetrated, consequential to a defensive "retreat into the self" (Gadow, 1984, p. 68).

Many of the critically ill also bear the weighty burden of grief (L. *gravis*, which means 'heavy'), the aftermath of many losses, the litany of which may encompass the body, the relationship with the self, and relationships with others (Cassell, 1991). For example, the body may lose some of its ability, perhaps because of a loss of some aspect of its structure, function, mobility, expressiveness, or strength. It may lose its stability, reliability, or predictability and thus take away one's self-reliance, independence, or control as well as one's ability to enact various roles or fulfill preexisting dreams, goals, and ambitions for the future. Subsequently, such loss may extend to one's relationship with the self in the form of a loss of self-esteem, self-worth, self-respect, self-confidence, self-image, or self-identity. It may also extend beyond the self and affect one's external relationships; for example, as reflected in a loss of a sense of belonging or a loss of a sense of connectedness to others and to one's world.

As well, there is often the ongoing "threat" of loss—for example, the loss of life, limb, or livelihood—which, undoubtedly, would primarily serve to accentuate the burden of fear. Likewise, and particularly in critical illness situations in which the underlying circumstances are unchangeable or inescapable (e.g., permanent disfigurement or disability), the potential for the critically ill to lose hope remains ever present. Thus, the haunting burden of hopelessness may also loom among the ruins of their broken worlds. Undeniably, the occurrence of such a loss as this would evoke intense and unbearable suffering. However, given the incredibly devastating long-term impact that this loss would also have on recovery and one's ability to lead a liveable life, further discussion regarding the significance and importance of hope in the critical illness experience will be more appropriately contained within the context of the forthcoming theme "making the unliveable liveable."

While they related their experiential accounts, the critical care nurses substantiated the burdensome nature of critical illness, including the trials and tribulations associated with diagnosis and treatment in the critical care unit. Yet simultaneously, their experiences and stories reveal their capacity to make a difference by making the unbearable (or potentially unbearable) aspects of critical illness and its associated care more bearable for critically ill patients. As "caretakers of suffering" (Morse, 2001, p. 47; Morse, Whitaker, & Tasón, 1996, p. 91), critical care nurses act or interact in multitudinous ways to help critically ill patients to bear, to endure, to "*get through*" the "burdensome" aspects of the critical illness experience.

Tempering Fear

"The critical care nurse is the stabilizing and reassuring force in what can be a very threatening environment" (Washington, 1990, p. 420).

> *While this is our world and we are so used to it, ICU is a REALLY terrifying place for a lot of people, not only [because of] the invasiveness of what we do, but [also because of] the sound of the equipment, the noise, and the rolling to and for.*

Critical illness and its associated care create conditions in which a world full of threatening things, events, and people comes into existence. Thus, it is hardly surprising that the burden of fear is considered among the most burdensome that the critically ill bear. And although some of the threatening aspects of the critical illness experience have been mentioned in passing, as, for instance, in the above comments by a critical care nurse, a comprehensive account of the fear associated with critical illness has yet to be given. Thus, what follows is a composite (and somewhat poetic) description of critically ill patients' fearsome plight, the intent of which is to offer deeper insight into the burdensome nature of their fright.

As the critically ill pass through the fortress doors of the critical care unit, they enter foreign and unknown territory. "Foreigners" now, they are confronted by an army of strangers, a legion of alien weaponry, a host of unusual and often unpredictable events, a gushing of peculiar and alarming sounds, as well as a profusion of unconventional and incomprehensible conversations. As enemy targets in the ongoing fight against life-threatening disease or injury, their now captive bodies are subjected to a barrage of brutally painful attacks from which, ordinarily, they would without hesitation pull back. A highly contagious aura of tension and seriousness often pervades this space and, regrettably, adds to the terror of being in such a "*frightening*" and "*terrifying*" place.

As they encounter the "unfamiliar," they may begin to feel very "strange," a feeling that is often compounded by the fact that "the familiar" (e.g., people and possessions) is also missing or currently outside their range. The usual daily march of routines, rituals, and practices that gave temporal structure and meaning to their lives comes, for the time being at least, to a grinding halt (Bergsma & Thomasma, 1982; van den Berg, 1966), a problem for which the commanding routines, rituals, and practices familiar to the "higher" ranks may be somewhat at fault. Therefore, is it any wonder that these captives feel fearfully uneasy, ill at ease, or insecure, particularly when "*the picture*" is left obscure? Or, for that matter, their futures are so uncertain, so unsure?

With the security of a familiar existence left behind, it is easy for fear to occupy the mind. Some may dwell in a state of fear because they know that there is no mistake: Their very existence, their life, is now at stake. For those who have indeed reached life's last milestone, a major fear might be that of being abandoned and dying alone. For those with bodily symptoms, particularly if they are overwhelmingly severe, it may be the inexplicability of them that accounts for much of their fear. For those without the proper knowledge of what next to expect, it may be that their imaginations are running wild, envisioning the absolute worst rather than something somewhat mild. And for those who on the basis of past experience can speculate on what is ahead, the anticipation of more trauma likely fills them with thoughts full of dread. For those who are lost in a cloud of confusion, it might be the delusion that extreme danger is near that is, for them, a major source of fear. Or, for those with "*ICU psychosis,*" their fear, believe it or not, just might be what "those others" are trying to plot.

While with the passage of time the critically ill may become more accustomed to the place, they may experience varying degrees of apprehension following the disappearance of a trustworthy nurse with a kind and caring face. Or if, for example, they are being weaned from the "*breathing machine*" [the mechanical ventilator] –the "*lungs*" they have come to embody—the process may generate a sense of panic that may be overpowering to a persistently frail body.

There are many ways in which the critically ill manifest their fear, and even its most subtle signs are easily recognizable by those who dare to be "near" (as in genuinely present). Those who are feeling "open to attack" are likely to be "on the alert," for they are quite certain about the potential that there is to cause them to hurt. For those who feel that they have suddenly fallen victim to "a surprise attack," they may either freeze in horror or wage a counterattack. And in so doing, they unfortunately place themselves in harm's way, much to everyone's concern and dismay. For those who are feeling "left in the dark," on an exhausting radar-like search for "the missing pieces" they will embark. The answers to many questions about their experience they will seek, using questioning eyes if they are unable to speak. Others may cautiously reach out or grope, a way for them to get "in touch" with their experience, they undoubtedly hope.

For those who feel that the slightest admission of fear would diminish their sense of pride, from behind a brave face they may attempt to hide. Yet despite their best intentions, fear is not that easy to keep concealed, and in the form of "*demanding*" or "*difficult behavior,*" it may eventually be unconsciously revealed. For those who feel overpowered or a sense of paralyzing defeat, the option they choose may be a secluding self-retreat (Gadow, 1984, 1985). And as they enter the state of pure subjectivity (Gadow, 1984, 1985), they will cease to participate in any surrounding activity. As the poet W. H. Auden (1966), in his description of the surgical ward, writes:

> They are and suffer; that is all they do;
> A bandage hides the place where each is living,
> His knowledge of the world restricted to
> A treatment metal instruments are giving. (p. 134)

And finally, those with fear rooted in paranoia or confusion may muster a fight, surprising many with their show of might. And while it might be necessary that they be disarmed, we now know that some of the methods used (e.g., excessive sedation and restraint) may, sadly, leave them more harmed.

No matter the cause or extent of fear, the state of mind common to all who are afraid is the feeling that a particular threat "that matters" (e.g., death, injury, pain, loneliness, total physical dependency) is near (as in "coming close"; Myerson, 2000, p. 47) or within the realm of possibilities in the still yet unknown. And, like anything else that enters the mind, fear too finds its way into the workings of the body (Cousins, 1989) and takes its toll, with its bodily responses (e.g., physiological and behavioral) playing a role. For example, as fear floods the mind and seeps into the body, the body's physiological responses (e.g., increased muscle tension, vessel constriction, and increased heart rate) create energy demands that may tax an already encumbered body, posing an immense challenge to one's endurance, thus making the critical illness experience more strenuous, or simply impossible, to bear. One need only consider the exhausting effect of the added strain of continually reconnoitering foreign terrain (Zaner, 1985), seeking information to help decipher a situation that is anything but plain, or, for that matter, the wearying effect of the continuous stress of constantly being on the lookout, looking out for anything that may be considered "dangerous."

Similarly, yet ironically, the body's behavioral responses to fear too may significantly add to the burdens that the critically ill bear. Just as danger can breed fear, so can fear breed danger. For example, as critically ill patients undergo invasive procedures that are unpleasant, uncomfortable, or painful (e.g., "*line insertion,*" endotracheal intubation, or suctioning), they may feel "under siege," and, quite naturally, become fearful. Yet, full of fear, their bodies may tremble, flounder, or freeze and, particularly during procedures that require dexterity, proficiency, and precision, endanger their safety. And should they sustain harm, injury, or additional pain, their burdens may intensify, thus making the experience of critical illness exceedingly difficult, or plainly too much, to bear.

Yet despite the burdensome nature of critically ill patients' fearsome plight as described above, the experiential accounts of critical care nurses reveal that, by tempering patients' fear, they are able to make their patients' experiences of critical illness and critical care more bearable. Yet one wonders how this tempering of fear comes to be. What nursing actions and interactions are considered key? How is this tempering of fear experienced by the critically ill? What difference does it make for critically ill patients?

Owing to the various underlying threats or threatening situations that may exist or coexist for the critically ill, it stands to reason that critical care nurses use a diverse number of strategies to temper patients' fear. Although the strategies may vary somewhat on the basis of each patient's particular situation, a number of strategies are commonly used by virtue of the fact that, given the circumstances surrounding critical illness, the critically ill share many of the same underlying threats or threatening situations. The following discussion, however, will primarily focus on the strategies that nurses commonly use to temper fear arising from the underlying threats of unfamiliarity and uncertainty. Thus the strategies that nurses commonly use to temper the fear arising from the underlying or accompanying threats of pain, injury, death, and so on will more pragmatically be given due consideration in forthcoming subthemes. Before proceeding, however, a little recap vis-à-vis the underlying threats of unfamiliarity and uncertainty seems in order.

For the critically ill who are held captive in the critical care unit for diagnosis and treatment of life-threatening disease or injury, the taken-for-grantedness of life, the taken-for-grantedness of the body, and the taken-for-granted sense of safety and security in a familiar and relatively predictable world have been sabotaged. The secure relationship that they once had with their bodies and their worlds has now become insecure (Hawley, 2000a).

As the victims of critical illness, those assumed to be conscious or who are recovering consciousness suddenly become acutely aware of their bodily existence (van den Berg, 1966) and discover that their bodies "no longer function in familiar ways" (Bergsma & Thomasma, 1982, p. 152). Their afflicted bodies feel alien, in no way their own (Bergsma & Thomasma, 1982). No matter how localized their bodily afflictions, they experience an overall sense of "dis-ease," a generalized sense of uneasiness about their now strange bodies (Bergsma & Thomasma, 1982; van Manen, 1998). Their bodies, once faithful allies, have become unfaithful (van den Berg, 1966). Now pursuing their own paths, their bodies are placed beyond control, leaving them with a strong sense of bodily mistrust (Bergsma & Thomasma, 1982).

Now in foreign territory, strange sights and sounds surround and invade them like another enemy (Barritt, Beekman, Bleeker, & Mulderij, 1984). Their bodies, now entangled in a web of invasive lines and protruding tubes, are shackled to monstrous and mysterious machinery. Their bodies feel small, heavy, and confined. Their movements impeded (L. *impedire*, which means ‘to shackle the feet of’), they feel bodily trapped. Suspicious and afraid, their state of awareness heightens (Barritt et al., 1984). They remain “on guard,” watchful, vigilant. They seek out everything that is strange.

Their familiar and trusted worlds have been abruptly left behind. The sense of security that they experienced through “the routines of life, the humdrum marks of daily existence” (Bergsma & Thomasma, 1982, p. 87) is, for the time being at least, undermined. They now feel a very strong sense of insecurity (Bleeker & Mulderij, 1992).

While barely grasping the totality and calamity of their current circumstances, the critically ill now face a situation that is also replete with uncertainty, unpredictability, and contingency. Not knowing what has happened or what will happen leaves many baffled, bewildered, or perplexed. And amidst the threat of the unforeseeable, there lurks the threat of death and danger. They become anxious and worried about what awaits them.

In response to the questions posed above regarding the key actions and interactions that critical care nurses use to temper fear, the description immediately below specifically, yet not unexpectedly, targets the tempering of fear that arises from critically ill patients’ encounter with the unfamiliar and uncertain world of critical illness and critical care. Reference to several anecdotes along the way will prove worthwhile.

In many respects the anecdote about Freeman that I introduced earlier in another context exemplifies a situation in which a critical care nurse manages to temper the experience of fear arising from unfamiliarity and uncertainty and thus merits revisiting. If you recall, Freeman was the patient who woke up in the critical care unit following emergency neurosurgery, having no recollection of arriving there. Intubated, and therefore unable to talk, "*his puzzled face expressed his state of confusion.*" "*His eyes were full of questions: Where am I? What's going on? Am I going to be okay?*" He "*was obviously frightened.*"

At one time or another most of us have suddenly awakened from a deep sleep or a terrifying dream and momentarily did not know where we were or perhaps what day it was. For a fleeting moment we might have felt panic stricken—stricken with panic. Dazed, we asked ourselves questions that helped us to reestablish our orientation. After quickly "getting our bearings," we breathed a sign of relief. Then, "Oh, thank goodness"; all was well.

Now imagine waking up in a bed in the critical care unit, not knowing how you got there. Every sight and sound is foreign, unfamiliar. Many are outright scary. A tube down your throat prevents you from speaking. Your body is attached to all kinds of machinery but seems detached from your memory. Groggy and disoriented, you try to recall what you last remember. There are many unknowns. Frightening thoughts race through your head. For Freeman and countless other critically ill patients who, upon awakening from anesthesia or heavy sedation, shockingly find themselves in the ICU, this is the terror of a nightmare that is not a dream.

Freeman's nurse was observant and attentive. She recognized his fear. She understood his confusion. She knew he needed answers to questions he could not pose. She knew that he needed to feel safe, secure, protected. She knew that he needed to know that someone was looking out for him, watching over him, worrying about him. She sensitively and calmly responded:

> *In a soft, quiet voice I told him who I was and where he was. I simply explained what had happened to him, why he was here, what was going on, and the purpose of all the tubes and lines. I assured him that I would be there with him for the rest of the night. I prepared him for some of the routine procedures and*

> *tasks that he could anticipate, like checking his pupils and vitals, giving him medication, suctioning him, repositioning him, changing his bed, and so forth . . . . Freeman grasped and squeezed my hand. While looking directly and peacefully at me, he mouthed the words "Thank you."*

As reflected in the above account, both explanation and vigilant presence play pivotal roles in tempering the fear precipitated by critically ill patients' sudden and unexpected confrontation with the unfamiliar and uncertain world of critical illness and critical care. Both are central to the creation of an atmosphere of trust and the subsequent development of "a sense of security in spite of all calamities and all threats" (Bollnow, 1989a, p. 16).

By explaining (i.e., giving the details of, "throwing light on," clarifying, putting into words, or assigning a meaning to) things, events, and people, Freeman's nurse brought a much-needed sense of clarity and certitude to his bewildered state. As she named (as in identified) new sights and sounds, they became part of a more familiar, safe world (Barritt et al., 1984). And now with some assurance that he was "out of danger," so to speak, feelings of terror and panic were replaced by a sense of relief. With a portion of threat now removed, he was more at ease.

Knowing that somebody was indeed looking out for him and watching over him added to his sense of safety. He felt his nurse's vigilant presence in a protective trusting way. Thus, rest assured he no longer had to "be on the lookout." He no longer had to "keep watch"

Knowing that somebody was worrying about him, Freeman did not have to worry unduly himself (van Manen, 1991). Knowing that somebody was attentively caring (Du. *zorgen*, which means "to care for someone in a worrying kind of manner"; van Manen, 2002a, p. 266) for and about him, he now felt more secure (L. *secura*, which means 'free from worry'). He had attained some peace of mind. As he sought his nurse's attention with his squeezing hand, his peaceful face, grateful eyes, and thankful words succinctly expressed his feelings. They were his way of saying, " I understand. I trust you. I feel safe."

The anecdote about George, the patient with Crohn's disease who, despite numerous previous hospitalizations, was admitted to the ICU for the first time, reinforces some of the commonalties in the experience of the unfamiliar and uncertain world of critical illness and critical care. Yet it also highlights the notion that, in the face of this unknown and uncertain world, the working of one's imagination may contribute significantly to one's experience of fear in relation to upcoming or imminent experiences. One's sense of vulnerability often becomes overwhelming and associated with magnified fears. As Morse et al. (1995) explain:

> There are times during an illness or recovery from an injury when the anticipation of an impending and dreaded experience or an expectation of violation becomes all consuming, leaving patients feeling an overwhelming sense of vulnerability. Imagination allows the body to experience anticipated treatments or situations first hand, often focusing on the worst parts of the experience or outcomes. (p. 16)

Sharing a similar view, Ferguson (1991) proposes that,

> when faced with uncertainty, . . . the mind tries to make meaning. The emotions can easily hold sway, carrying one away with thoughts of disaster. During these moments or hours one feels trapped, captive to the terror of what might be possible. (p. 316)

As is often the case, the mind may envision many unrealistic things. For example, as George's nurse recounts:

> *A lot of patients think that as soon as you put them on a ventilator, . . . they're going to be on it forever.*

Anticipating that this thought might be one that George's frightened mind could conjure up, she responded to his fear-filled eyes by saying: "*You don't have to be scared. This is what we're going to do.*" She "*explained it all to him,*" adding:

> *We don't want this to be a permanent thing. You're just a little unstable right now, and we will get things under control and then take this tube out.*

As a result of her explanation and hint of genuine reassurance, he was able to "*relax.*" "*The worry in his eyes just kind of disappeared. His muscles were no longer rigid. The procedure was successful.*"

With his nurse's explanation and reassurance that everything would eventually "*get under control,*" George was able to achieve a more realistic and optimistic perspective on his situation, and perhaps settle his imagination. No doubt he also sensed that, to some extent, his nurse already had things "in control." Feeling that he was in reliable and capable hands, "in good hands," he was able to relax and trustfully "hand over" his body to the uncomfortable and risky, yet necessary, procedure of endotracheal intubation. Using the words of van Manen (1998), he "surrendered to the trust of the caring other" (p. 18). As a result, the procedure was executed safely.

Even for what some critical care nurses may consider the simple, routine, and hence mundane procedures or tasks that must be carried out, a little explanation and reassurance to patients goes a long way. As one critical care nurse commented:

> *When you let them know what you're doing and what to expect, they put so much trust in you. It's all very important in helping them to just relax.*

Or as another related:

> *A lot of patients want to know what is happening, what you are doing, and to some degree why you are doing it—not that you have to become so technical [about it] or give the chemistry of it all, but they feel much more assured, even if it's simple things like, "I'm going to put this pressure cuff on you. You're going to feel a little pressure for a few seconds; it doesn't mean that there's something wrong. . . . It's just a part of the checking [on] how everything is." You can really sense their fear if you don't tell them these things.*

As previously mentioned, in many instances of critical illness and its associated care there are no alternatives to the unpleasant, uncomfortable, and painful treatments and procedures but to "surrender to . . . [them] as a condition of life" (Olson, 1993, p. 117). Hence, critically ill patients often have no other alternative but to bear them, to endure them, to "*get through*" them. Oftentimes, however, "preprocedural" explanation, including sensation information, is invaluable in that it provides patients with time (as in an opportunity) to mobilize their coping abilities, particularly those that will enable them to retain or remain in control. Yet a few words of caution are expressed by a critical care nurse who stresses that, in attempting to "*help those who are scared,*" it is important that nurses "*give the right amount and level of information.*" She wisely counsels:

> *You don't want to overwhelm them. With too much information, they get more scared and restless. You need them to be calm and cooperative to avoid harm and danger.*

And for those who are confused, combative, and perhaps terrifyingly "searching for the fastest escape route" (Heron, 1987, p. 285), reassurance that no one is "*trying to hurt them or out to get them, but rather that everyone is trying to help them,*" is as crucial as explanation and the timely administration of both pain medication and sedation. As in any terrifying event, reassurance is a remarkable "purveyor of trust" (Olson, 1993, p. 149), the trust that critically ill patients need to forfeit their vigilance and surrender their bodies to care.

Before continuing to consider other aspects of unfamiliarity and uncertainty, it is important that I make some parenthetical comments about the tempering of fear in critically ill patients arising from change, necessary or otherwise. Whether it be the replacement of the caring nurse whom they have come to know and trust, the disruption of certain routines to which they have become accustomed to and bide their time by, or the weaning from the ventilator that they have come to embody and depend on for every breath, such change brings about a kind of "evolving" unfamiliarity and uncertainty that is capable of regenerating feelings of insecurity, unpredictability, and mistrust in critically ill patients, often manifested by anxiety, agitation, and apprehension, or varied attempts to resist (L. *resistere*, as R*e-sistere*, which means 'stop') change. Sound familiar? No doubt. After all, aren't such responses just "human nature," naturally "human" responses to change?

However, as revealed in the comments of several critical care nurses, the fearfulness of such change can be tempered by assisting patients to cope with necessary, yet frightening change or by attempting to avoid or minimize fear-evoking change that is unnecessary. With respect to the former, using the common experience of ventilator weaning as an example, one critical care nurse declared that *"you've got to 'be there,'"* implying that, not unlike other threatening situations, the successful weaning of patients calls or evokes the need for critical care nurses to engage in ongoing sensitive interactions such as sufficient and straightforward explanation and sincere reassurance as well as responsive and responsible actions such as "watchful vigilance." With respect to the latter, continuity in nursing assignment, to the extent possible, is touted by many nurses to be one of the chief (and, relatively speaking, easily achievable) ways to evade unnecessary fearsome change. As Bollnow (1989a) suggests, once a realm of security is created, consistency becomes a way to guard it. One nurse's remark, and uncontested by others, supports in principle the value of maintaining this kind of consistency in the provision of care:

> *It helps a nurse to have the same patient, but it also helps the patient to have the same nurse for a reasonable time, rather than having strangers coming all the time and having to get to know new people over and over again.*

No doubt you will agree that the more you get to know a person and his or her "modus operandi," the more likely you are to trust (or mistrust!) that person. Chances are, however, that in the context of the nurse-patient relation, an opportunity for a patient to "*get to know*" a nurse more deeply over time also translates into an opportunity for a patient to establish a deeper sense of trust—that is, trust in the sense of feeling more sure (derived from L. *securus*, which means 'secure') that he or she will not, under any circumstances, be criticized or scorned (Hames & Hunt, 1980; van Manen, 2002b); as well as trust in the sense of feeling more confident about a nurse's ability to take good care of him or her (Bollnow, 1989b). Accordingly, consistency in nursing assignment can ultimately provide a patient with some degree of predictability, enhance feelings of security, further relaxation, and indeed also afford the more timid (L. *timidus*, which means 'fear') patient an opportunity to safely, trustfully, and "fearlessly" talk about, and perhaps talk out (as in overcome), his or her fears.

Aside from the short digression above, the discussion related to the tempering of fear that arises from the unfamiliar and uncertain world of critical illness and its associated care has thus far focused primarily on the strange and frightening surroundings of the critical care unit and the threatening nature of imminent events, particularly those of an invasive and painful nature. However, simultaneously, as mentioned earlier, many critically ill patients also experience a certain degree of fear consequential to uncertainty about their future; for example, about what is going to happen to them (Bergsma & Thomasma, 1982) or whether or not they are "going to make it," and so on—an experience perhaps best described as "fear-as-worry," a kind of subtle, yet "wearying," mental (late L. *mentalis*, which means 'mind') struggle as one's mind dwells on the bodily concerns, difficulties, and troubles that have ensued as well as the associated "what ifs."

John, the patient in his late 50s or early 60s who underwent a liver transplant, seems to portray this kind of "worrying mindfulness" (van Manen, 2002a, p. 265), a state in which his mind was full of worry. His nurse sensed that he was "*having a difficult time to relax and deal with everything that was going on.*" It seemed as if "the heavy things that were worrying him" (p. 264) were adding to his already weighty burden, "*the heavy work of trying to stay alive.*" Sensing the need for a rest from all the stress and strain, his nurse chose to try the "*relaxing technique*" of imagery.

> *I calmly asked him to try and see if he could go far away from where he was right here, to go to a place, his favorite place, wherever that could be—a nice relaxing place with water or a forest—to go to some quiet place where he could just completely forget where he was with all the pain and the heavy work of trying to stay alive. Whether it was that or just my voice, he started to relax. His breathing got easier. His heart rate went down. His blood pressure went down. Later, I also gave him a foot massage and he responded to that. Just working on relaxing him made the night go just so much easier for him and he didn't have to be ventilated.*

For those who are critically ill and burdened by worries, imagery, a form of distraction, can provide a time of respite, a temporary reprieve from the "occupation and preoccupation" (Benner & Wrubel, 1989, p. 136) of illness. And coincidentally, it can also provide a much-needed escape from the tension that is inescapably transmitted from the tense (and intense) milieu that is characteristic of the critical care unit.

As illustrated in the above account, imagery worked for John. With her voice serving as a calming stimulus, John's nurse enabled his mind "*to go far away to some* *quiet place, his favorite place,"* perhaps near streaming water or gently tiding waves, or under the mantle of the trees in the forest, where he could distance himself from his trials and tribulations and vicariously reexperience a time when he was worry free, carefree. Thus, freed from his worrying thoughts, his cares, he was able to quiet (L. *quietis*, which means 'rest') the struggle. Not unlike finding "a port in a storm," he was able to rest his mind and, in turn, his body. Absorbed in the tranquility of the setting, he was able to relax, curb his energy expenditure, and perhaps even soak up some recuperative energy.

Many nurses would no doubt agree that other forms of distraction also work well to relieve tension, promote relaxation, and provide "rest for the weary." As one nurse commented in reference to reading a book aloud to a patient, "*You just want their minds to wander for a while.*" And sometimes that may even involve going for a wander [as in stroll] outside the critical care unit or perhaps even outdoors. And just providing opportunities for critically ill patients to do some "normal things"—to play a game of cards, to watch a hockey game or a movie, to listen to some music, or to simply engage in chitchat about everyday things—also provides them with a chance to "step out" (Bottorff et al., 1995, p. 1080) for a while.

Likewise, the use of humor in its many forms can also provide critically ill patients with a temporary diversion, "a breather" (Klein, 1989, p. xvii), a chance to temporarily distance themselves from the grave (L. *gravis*, which means 'serious') and frightening matters that burden and weigh them down. Or, as one nurse expressed it, the use of humor creates "*a space [for patients] to let go of their fears and worries.*" Whether it is used somewhat spontaneously, in the form of cracking a little joke, telling a funny story, playing on words, striking a comical pose, sharing a cartoon, posting a funny picture, pulling a silly prank, engaging in tomfoolery, adding a "side comment," or making a jest remark, and so on, or it is preplanned—for example, turning the TV on to a certain feature on the comedy channel or just in time to catch a humorous sitcom—the use of humor affords the critically ill an opportunity to rest their burdens for a while—to relax their bodies, to replenish their strength, and perhaps even to rejuvenate their spirits (Cousins, 1979; Wooten, 2000)—before they carry on.

As well, the use of humor can have a "normalizing effect" (Leiber, 1986, p. 163) on the critically ill and thus engender a sense of reassurance, a feeling that indeed things are okay, sometimes despite major setbacks. As one nurse expressed it:

> *I believe that patients feel reassured by the fact that, if we are able to show a sense of humor, still joke or laugh, whatever, then things can't be so bad.*

Another critical care nurse drew the same conclusion when, after teasingly questioning a patient about the motive for her return to the CVICU within two hours of being transferred to the step-down unit, the patient, who had in the interim developed a pulmonary embolism (a life-threatening complication) and had to be reintubated, responded to the nurse's question with a relaxed smile and a casual shrug of her shoulders that jovially claimed her innocence.

Moreover, the cultivation of a climate of lightheartedness (which includes the use of humor) can help to lighten the heaviness of an otherwise serious and tension-filled atmosphere. While emphasizing the value and importance of creating a lighthearted atmosphere, a critical care nurse had this to say:

> *Humor is one of the best things. It really relaxes people, [that is,] patients and families. They see that you've got to take some things light, because if you don't, you're just going to freak out.*

In passing, another commented generally that, "*with a little humor, you can often feel the tension dissipate.*" And so by just singing a cheery song, for example, or whistling a happy tune, stepping a lively dance, dressing up in clown-like fashion, flashing a teasing wink, or simply wearing a twinkling smile, critical care nurses can break mounting tension or take the edge off tense situations and thus help to turn frightening and burdensome experiences into lighter and more bearable ones (van Manen, 1991).

As well, by example, a light-hearted atmosphere may also trustingly invite critically ill patients to initiate humor that may include, and not by accident, the "humorous" expression of their fears, fears that might otherwise be too difficult to express (Warner, 1986). And as a result, the critically ill are provided with another means to release tension and experience relief (Warner, 1986). By providing critically ill patients a safe and acceptable outlet for such self-expression, humor can be considered to have an "unmasking quality" (Perry, 1998, p. 91). And in addition to being able to express their fears with less risk, their fears may at the same time be re-framed or rendered less powerful. Or as Leiber (1986) asserts:

> Under frightening or unpleasant conditions, going through the motions of humor can prevent one from being overtaken by the fearfulness of a situation, and can make the feared tragedy of the moment seem temporary. From a 'self preservation' perspective, finding some humor in an overwhelmingly [frightening] . . . situation can not only help to make it seem less so, but can help to preserve the positive energy needed to cope with [it] . . . as well. (p. 163)

Although there is "much nonsense in humor," the virtues of humor, as extolled by many, support the notion that there is "some sense in humor" (Baughman, 1974, p. 51), that it indeed serves many worthwhile purposes. Of particular interest here is its beneficial effect on the earnestness of everyday life. For example, one of the traditional proverbs pithily refers to humor as the pole that adds balance to our steps as we walk the tightrope of life. Baughman (1974) regards humor as "our sixth sense, . . . as important as any of the other five" (p. 52). He describes humor as "that soothing and compensating peace of mind which prevents us from being overcome by life's adversities" and as that which "can dissipate the fog and make life more enjoyable and far less threatening" (p. 52). Specifically, he claims that humor, "like a tranquilizer," "helps us relax," "dissolves tension," and "frees the mind" (p. 52), and thus "eases the accumulating burdens we bear" (p. 53). Likewise, references to the value and importance of lightheartedness bear equal merit. For example, Taylor (1994) referred to lightheartedness as "levity above the everyday circumstances that cloud our minds and weigh our bodies down" (p. 216), and, as such, "seeks to aerate the lead ball of life and turn it into a bright balloon" (p. 216). And last, but not least, consider the wisdom in these chorus lyrics from the song "Pack up Your Troubles in Your Old Kitbag," written by George Asaf and now synonymous with World War I: "What's the use of worrying? / It never was worthwhile. / So pack up your troubles in your old kitbag, / And smile, smile, smile!"

Given the beneficial effects of humor and lightheartedness described above, it is not surprising to discover that they have such therapeutic value or "healing power" (Klein, 1989; Wooten, 2000) when appropriately used with patients in situations surrounding critical illness. In fact, how often have you come across Proverbs 17:22 from the Old Testament, which says, "A merry heart doeth good like a medicine; but a broken spirit drieth the bones"? How often have you heard such sayings as "laughter is the best medicine" or "laughter is the antidote to the misfortunes of life"? Or, for that matter, how often have you made, or overheard, the comment that so-and-so could use "a dose of humor"?

What is surprising, however, is that, given their many benefits, humor and lightheartedness in the highly technical and serious environment of the critical care unit still tend to be considered unprofessional and are "frowned on" by some, pardon the pun! A passing comment made by a critical care nurse who had previously and wholeheartedly claimed that "*patients like a little bit of lightheartedness*" reflects this rather ironic situation. She remarked:

> *While some may think that some [of the] things [that we do or say] are unprofessional, if you can make a patient laugh, you create an environment where there is a lot less tension.*

In the broadest sense, humor is considered to be a phenomenon that is conducive to producing laughter and fun (Åstedt-Kurki & Liukkonen, 1994; Leiber, 1986). However, as several critical care nurses have qualified, humor that is therapeutic in nature is humor that is contextually appropriate, timely, and suited to the patient's unique sense of humor. They also claimed, like Leiber, that humor has no place at the height of a serious crisis. Nor does it embarrass, exploit, hurt, humiliate, insult, mock, offend, or ridicule. Rather, they advocate, as does Bollnow (1989b), that therapeutic humor be "couched and supported by warm human goodness" (p. 60) and intended to cause one to laugh at oneself or together with others (Åstedt-Kurki & Liukkonen, 1994; Leiber, 1986). Accordingly, these nurses believe, similarly to Benner and Wrubel (1989), that its success requires impeccable skill and a sensitivity based on "a deep background understanding of the situation and at least a modicum of trust and respect" (p. 18); or, as one critical care nurse succinctly put it, the ability to "*read people and take it from there.*"

Wooten (2000) suggests that, "after the laughter, as the person becomes quiet, a warm glow fills the body. The person feels lighter, almost buoyant, and the mind is clear of worry, fear, and anger. The body feels energized yet relaxed" (p. 478). Yet one wonders how humor produces these beneficial effects. For example, how does it help the body to relax, to release its tension? Is it just the result of the workings of the mind, those effects often referred to as the psychological effects? Cousins (1979) claims not. In his widely acclaimed work "Anatomy of an Illness", he reveals that, indeed, such benefits are due in part to the physiological responses that ensue from the laughter.

According to Cousins (1979), "Laughter is a good way to jog internally without having to go outdoors" (p. 84). With a good laugh every organ in the body gets a workout—"more organs than the person thinks he [or she] has," adds Baughman (1974, p. 59). Think of the last time that you had a good mirthful laugh. As Burkhardt and Nagai-Jacobson (2002) propose:

> Recall . . . how it began with the muscles of your face around your lips and eyes, your eyes twinkling and your breathing changing, your throat and vocal cords becoming involved as noises of snickering, giggling, and hooting came forth. The muscles of your chest and stomach became involved as the noises got louder and deeper, and your breathing might have become almost gasping as the laughter got deeper. You might have started crying or felt like other body functions might be hard to control. After laughing for a while, you may have felt like you had a real workout and needed to just sit and rest. (p. 196)

Although at the time you may have been aware of all of this going on, you were probably not as aware of what was occurring internally. In summarizing Fry's research into laughter, Klein (1989) very generally notes that laughter exercises the heart and lungs, releases muscle tension in many major muscle groups, and promotes the release of endorphins (the body's natural opiates) from the pituitary gland into the bloodstream, contributing to the phenomenon commonly described as a "runner's high" (p. 19). And so, given the research into the physiological responses to laughter, we can conclude that its physiological effects are therapeutic in their own right (Leiber, 1986)—all the more reason for critical care nurses to promote a round of laughter in their critically ill patients as they bear the formidable burden of fear and strive to "soldier on."

And so, in departing from this subtheme, tempering fear, I believe that it seems reasonable to conclude that, given their experiences and stories, these critical care nurses possess a "good sense of humor," philosophically and behaviorally (Wooten, 2000) and know that the use of humor in the care of the critically ill is certainly worthwhile. As the major allied force battling on the front lines, they have come to know how and when to make their frightened, anxious, and worried critically ill patients smile and "pack up their troubles," even if it's just for a short while.

Conquering Bodily Dis-comfort

"There is nothing that concerns the comfort of the patient that is small enough for her [the nurse] to be careless about" (Aikens, 1908, p. 422).

As mentioned, the experience of critical illness, including the ordeal of diagnosis and treatment, brings with it a myriad of burdens for the critically ill to bear. Notably among them are the torturous and taxing burdens of bodily pain and other bodily afflictions. Whether they arise from "hidden and mysterious" (Madjar, 1998, p. 81) pathophysiological processes within the body, unmet inner body demands, "external and visible" (p. 81) bodily assaults or states incurred during the course of diagnosis and treatment, or the imposition of unpleasant environmental conditions (e.g., extremes of noise, light, or temperature), they are considered to be significant sources of bodily dis-comfort and thus in some manner bring the "sensitive body" (Bleeker & Mulderij, 1992, p. 8) "to center stage" (Zaner, 1985, p. 82). Hence, the reality that one not only "is" one's body, but that one "has" a body comes brutally into awareness (Bergsma & Thomasma, 1982).

While bodily pain remains one of the major sources of dis-comfort among the critically ill, it also shares many of its characteristics with other dis-comforting bodily afflictions. Therefore, although the brief description that immediately follows will focus primarily on the phenomenological structure of the experience of intense bodily pain, inflicted or otherwise, keep in mind that one or more of its lived dimensions may apply in some measure or fashion to other forms of bodily dis-comfort as well.

No matter its source, intense bodily pain is an aversive, intrusive, and unbidden experience (Madjar, 1998). It is "an embodied sensation unequaled in its immediacy and demand for attention" (p. 109). Or as Leder (1990) expressed it, "One's attention is summoned . . . in a way that it would not be by a more neutral stimulus", or as it would be "by other experiences of the body" (p. 73). And as the pain powerfully seizes one, one's lived space, time, and relationships, essentially all aspects of one's world or being, are affected. For example, pain tends to induce "self-reflection and isolation" (p. 75). It also effects a "spatiotemporal constriction" (p. 75), a perceptual constriction of space and time that is also often accompanied by a "motoric constriction" (p. 75).

As Leder (1990) elaborates, "Unlike the feel of a cold wind, pain is marked by an interiority that another cannot share" (p. 74). Madjar (1998) agrees by saying that "whatever others may understand about a person's pain, its essential painfulness can only be lived, not shared" (p. 74). Or, as Scarry (1985) explains, pain is "not available to sensory confirmation" and thus it "comes unsharably into our midst" (p. 4). She adds:

> When one speaks about "one's own physical pain" and about "another person's physical pain," one might almost appear to be speaking about two wholly distinct orders of events. For the person whose pain it is, it is "effortlessly" grasped (that is, even with the most heroic efforts it cannot *not* be grasped); while for the person outside the sufferer's body, what is "effortless" is not grasping it (and . . . [even] . . . if with the best effort of sustained attention one successfully apprehends it, the aversiveness of the "it" one apprehends will only be a shadowy fraction of the actual "it"). (p. 4)

The experience of intense bodily pain pulls one back from the future (and its possibilities) to the here and now, the present (Bergsma & Thomasma, 1982; Leder, 1990). In the words of Buytendijk (as cited in Bergsma & Thomasma, 1982), "Only a pain-filled now exists" (p. 113). "The clock stands still, as it were" (p. 21). It is as if there is "no future," only a "present that stretches forever" (Morse et al., 1995, p. 17). And in addition to drawing one back in time, the experience of intense bodily pain also draws back one's attention not only toward one's own body, but also often toward a particular body part (Leder, 1990). As Scarry (1985) explains, intense pain is experienced spatially as either the contraction of one's world down to the immediate vicinity of the body or as the body swelling to fill one's entire world. One's whole world seems permeated by pain; "there is room for nothing else" (Bergsma & Thomasma, 1982, p. 113). And as the possibilities for movement become restricted or encumbered, potentially "every move is a small conquest" (van den Berg, 1966, p. 27).

According to Scarry (1985), the experience of intense bodily pain is "also language-destroying" (p. 35). She explains it thus: "As the content of one's world disintegrates, so the content of one's language disintegrates; as the self disintegrates, so that which would express and project the self is robbed of its source and its subject" (p. 35). As a result, not only does this contribute to pain's unsharability, but it is also what often reduces its expressibility to primordial cries, screams, moans, and groans (Madjar, 1998; Scarry, 1985), which, in turn, may ultimately contribute to the experience of pain as one that is also potentially de-humanizing (Madjar, 1998).

As indicated earlier, the suffering associated with the experience of intense bodily pain is often intensified by accompanying fear. Bodily pain that is inflicted on the critically ill during the course of diagnosis and treatment is considered to be inherently threatening and thus evokes immediate (as in direct) fear. In contrast, intense bodily pain that arises from underlying pathophysiological processes represents a signal that whatever is occurring internally is unusual and threatening to the body (Bergsma & Thomasma, 1982) and thus indirectly evokes fear, particularly when its origin or meaning remains unknown or uncertain. And last, but not least, the experience of intense bodily pain is, as is its counterpart fear, one that also saps energy and drains vitality and hence can leave exhaustion and weariness in its wake.

Heretofore, and understandably so, the discussion related to bodily dis-comfort has primarily focused on those bodily afflictions—in particular, intense bodily pain arising from the various pathophysiological processes that underlie critical illness as well as from the various diagnostic and treatment modalities associated with its care. However, given the many and unusual circumstances surrounding the critical illness experience, including the critical care environment itself, additional sources of bodily dis-comfort may arise among the critically ill and thus also merit consideration.

Of particular import are the various unpleasant, uncomfortable, or painful visceral sensations associated with the body's normal physiological processes and its attempt to maintain a steady or homeostatic state, sensations that often intensify when the body's immediate call for attention goes unheeded (Leder, 1990). All of us have experienced these "biologically adaptive" moments when our needy bodies, having reached certain functional limits, have unpleasantly seized our attention and demanded our action (p. 84). We need only recall the hungry growl for food, the thirsting beg for water, the yawning plea for sleep, the pressuring appeal for elimination, the aching cry for movement, the shivering request for warmth, and the like, as our bodily demands for sustenance and vitality were explicitly brought into our awareness; and how, once fulfilled, the unpleasantness of the moment was quickly mollified. On the other hand, we can no doubt also recall uncomfortable, almost intolerable, moments when a timely response to certain bodily demands was for some reason postponed. Who has not had to endure the all-consuming pressure of a full bladder while eagerly anticipating arrival at the next service station, seemingly "miles away"? Who has not felt the overwhelming heaviness of one's eyes and limbs while yearning for the moment when one could finally collapse one's exhausted body into a bed? Who has not been gripped by a "frozen stiff" body while longing for the delayed driver who seemed to "take forever"?

Likewise, given the host of obstacles that the experience of critical illness brings, not the least of which is the body itself, there are undoubtedly times when certain inner bodily demands may not be fulfilled "on demand," and thus, like the everyday experiences cited above, they may contribute to a variety of acute bodily dis-comforts. For example, perhaps because of paralysis, paresis, pain, prescription, or paraphernalia, a critically ill patient's bodily movement may be restricted to the extent that even the most comfortable position eventually becomes uncomfortable. And as is often the case, such dis-comfort may be prolonged (and even compounded) by the fact that the patient may not be able to speak and therefore not able to verbally request permission or assistance to reposition in a more timely fashion. Meanwhile, and not unlike the experience of many other bodily afflictions, there is presently little or no room in the patient's world for anything else but this "sensitive body" (Bleeker & Mulderij, 1992, p. 8) that, as reflected in the example above, is now dis-abled and unable to function in its usual, taken-for-granted ways.

Similarly, this dis-abled body may also be a source of a rather unusual bodily dis-comfort in that, although it is commonly experienced among the critically ill, it is not typically considered as such, nor is it frequently given the recognition it deserves despite its rather low priority in the "overall scheme of things." Specifically, this is the bodily dis-comfort that results from not being able to independently engage in those habitual activities that ongoingly contribute to maintaining an external bodily state that one is familiar and thus "comfortable" with. From a phenomenological perspective, this translates into a bodily state in which one may no longer feel like "oneself," like one's usual embodied self, but rather may be unusually aware of one's body and its appearance (or odor) and perhaps also affectively experiences an accompanying sense of dis-ease as this loss of "a sense of continuity with . . . [the] usual self" (Benner et al., 1999, p. 249) tends to also color one's day or seems to make things go awry. For example, perhaps because of immobility, diminished strength, or lack of energy one may be unable to bathe or groom one's body in accustomed ways and thus may not achieve the usual bodily state of cleanliness or grooming that contributes to one's usual embodied state of comfort. Perhaps too as a result nothing else seems "to go easy" or "to feel right." No doubt many of you can relate, to some extent at least, to this uncomfortable bodily state as you recall a so-called "camping trip" experience of unwashed hair, an unbathed body, an unshaven face, a face left unmade (i.e., without one's usual make-up applied), or an atypical day—a so-called "bad-hair day" or a day in which you simply "got up on the wrong side of the bed." Just how appropriate and telling these common, everyday expressions about such unusual and out-of-the-ordinary events really are!

Similarly, and by way of conclusion, how astute and apropos is Nightingale's (1859/1992) observation. She writes:

> The symptoms or the sufferings generally considered to be inevitable and incident to the disease are very often not symptoms of the disease at all, but of something quite different—of the want of fresh air, or of light, or of warmth, or of quiet, or of cleanliness, or of punctuality and care in the administration of diet, of each or all of these. (p. 5)

Yet despite the inherently burdensome nature of bodily dis-comfort, the experiences and stories of critical care nurses reveal that, by conquering bodily dis-comfort in its many forms, they contribute to making the experience of critical illness and its care more bearable. Through a variety of actions and interactions, critical care nurses are able to conquer many of the unpleasant, uncomfortable, and painful bodily experiences associated with critical illness and its care before their critically ill patients are conquered by such experiences. Yet one wonders how critical care nurses conquer such bodily dos-comfort in their critically ill patients. What does this professional challenge entail? How do critically ill patients experience its success? Or what difference does it make for critically ill patients when such valiant efforts to conquer bodily dis-comfort are triumphantly met?

Given the array of causes and the varying degrees of bodily dis-comfort that burden the critically ill, it comes as no surprise that critical care nurses use a variety of strategies, often in combination, to conquer bodily dis-comfort in the critically ill. And while cognizant of the fact that the possible strategies used, and the combinations thereof, may vary according to each critically ill patient's unique circumstances and other contextual factors, in the following discussion I will only address the "more or less" typical (as in quintessential) strategies used by nurses to conquer those bodily dis-comforts most typical (as in characteristic) of the critical illness experience. And given that intense bodily pain, whether it arises from the illness, the treatment, or both, is considered to be one of the major sources of dis-comfort and has become a "prototype" of sorts, the strategies that nurses use to conquer intense bodily pain will surely figure prominently.

Given that fear frequently accompanies many bodily afflictions and thus often heightens the experience of suffering associated with bodily dis-comfort, it stands to reason that many of the actions and interactions of critical care nurses that specifically and successfully target fear (e.g., explanation, reassurance, vigilance) also indirectly help to diminish the suffering associated with all sorts of unpleasant, uncomfortable, or painful bodily afflictions. For example, as Bergsma and Thomasma (1982) suggest, explanation of the known cause or source of certain bodily afflictions, even if negative, is meliorative. Not unlike the experience of "diagnosis" (Cassell, 1991; Hayne, 2002; van Manen, 1998), when many puzzling or nagging questions and self-doubts about symptoms are put to rest, just "knowing" what certain bodily afflictions are, understanding them, making sense of them, and having some certainty about them can bring about a much-needed sense of relief. Or in cases in which necessary treatments and procedures involve the infliction of bodily dis-comfort, just "knowing" to expect dis-comfort and what to expect can be appeasing and reassuring, not to mention preparatory. Thus, whether it is the passing of a catheter, the suctioning a chest, the dressing a wound, the insertion of a line, the removal of a tube, the injection of a solution, the application of pressure, the turning, transferring, or mobilizing of an injured body, and so forth, simple, straightforward, and candid "preprocedural" reassuring explanation immediately beforehand goes a long way to minimizing those uncontrolled and risky behavioral responses of the body that are often evoked in the presence of fear, anxiety, and mis-trust, and as a consequence ultimately serve to make such unpleasant, uncomfortable, and painful treatments and procedures more bearable, more tolerable, more endurable, and, "safe to say," safer to execute.

That being said, however, some situations are exceptional in that such preprocedural explanation and reassurance alone will not suffice. Something more is needed to help critically ill patients "*get through*" them. For example, in situations of severe and all-consuming pain or when critically ill patients must bear the most painful treatments and procedures, nurses make such painful episodes or events more bearable by also liberally dispensing "*painkillers*," pharmacological ammunition, to seize pain in its tracks, and by "coaching" patients through each painful moment (Hawley, 2000b; Morse, 1992; Penrod et al., 1999). The following comments from several critical care nurses regarding the commonly performed, yet extremely painful and invasive medical procedure of "*line insertion*" are typical and illustrative. For example, certain key elements of "coaching"—specifically, tonality, time, and touch—and the ways in which each element in its own way and in combination with other elements helps critically ill patients to bear, tolerate, endure, and "*get through*" intensely painful situations without added bodily dis-comfort or injury are exemplified:

> *Often when a line is to be inserted, I give them painkillers. But they're in such intense pain. So just for me to be able to soothe them verbally, to tell them what's going on step by step, to say, "You're gonna feel this or you're going to feel that" or "It's almost finished" makes it much easier for them to cope.*
>
> *When the doc is doing a line insertion and the patient is just so scared, I say, "Just hold my hand; it's okay," and they hold my hand. Or I say, "Squeeze when it hurts," and they squeeze. Yeah, you can't take away all their pain, but you can actually help them cope, to get through it.*
>
> *It's important to at least be there, to hold their hand, or to just say things like, "Hey! You're doing great! It's gonna be okay. We're just about finished." The*

> *fact that you're there, that you explain things, that you hold their hand keeps them from fighting and struggling. And if you can't hold their hand, at least be standing close enough for them to hear you or see you, those kinds of things. That way you can help the docs and at the same time be there for your patient as a kind of go-between.*

As the above excerpts reveal, "coaching" critically ill patients through intensely painful episodes or events involves a great deal of verbal communication, a great deal of talking. And yet in these and other accounts there is an inkling that the beneficial effects of nurses' coaching talk may not be solely a function of the words, but also a function of the tone or the way in which nurses speak the words (van den Berg, 1966; van Manen, 1991). Whether the words are those of explanation, reassurance, praise, support, warning, or empathy, the tonal quality of nurses' voices also seems to be instrumental in helping critically ill patients to maintain or regain control—to relax, to focus their attention, to "hold on" during extraordinarily painful situations (Hawley, 2000b; Morse, 1992; Morse & Proctor, 1998; Proctor et al., 1996)—with a soothing, calming tone, or a melodic "sing-song" quality to the speech sponsoring a "quiet relinquishment to care" (Penrod et al., 1999, p. 38) and a more directive, commanding, but encouraging tone fostering "active cooperation" (Penrod et al., 1999, p. 32). Either way, the outcome is safely executed treatments or procedures with patients continuing to have some self-control whilst surrendering to necessary, often life- or limb-saving care. And fortuitously, by enabling patients to have some degree of self-control, the amount of control that might otherwise need to be imposed by others in the form of restraint or heavy sedation is reduced, resulting in another positive outcome—the safe execution of necessary treatments or procedures that are also experientially more dignified and less de-humanizing for patients.

As mentioned, another important element of coaching that is evident in the excerpts above is the reference to time; in particular, the future. As indicated earlier, during experiences of intense bodily pain, a future beyond the overwhelmingly painful present is difficult for critically ill patients to see. However, by making coaching statements such as "W*e're just about finished*" or "*We're almost done,*" nurses help critically ill patients to live through the extreme pain of the treatments or procedures. By indicating that an end is in sight or that a future beyond the pain is "in store," critical care nurses help patients to endure another agonizing moment, to "stand it" a little longer. No doubt those of you who have lived through any number of miserable situations can personally attest to how the anticipation of a different or better future, either immediate or long term, enabled you to better tolerate the hardships or deprivations of the present (Travelbee, 1971).

The final element of coaching is the use of touch and the role it plays in augmenting patients' endurance. As indicated in the above excerpts as well as in many passing comments, nurses use direct touch in conjunction with verbalizations to attract and hold patients' attention (Morse et al., 1994), to reassure, to calm, to soothe, or to simply "reach out" and supportively connect with patients who are in pain and painfully afraid. Unlike the palpating, probing, and manipulating "gnostic" touch (van den Berg, 1966; van Manen, 1999) required to skillfully perform such treatments or procedures, this kind of touch (e.g., the caressing of a hand, the stroking of a brow, or the gentle grasping of the shoulders) is a different kind of touch. It is a touch with a different purpose and thus has a differing experiential quality for patients who are undergoing intensely painful treatments or procedures. It is a "pathic" touch (Kleiman, 2005; van den Berg, 1966; van Manen, 1999)—a touch in which the hand is not an instrument but rather an extension of the self of the nurse offering possibilities for comfort in times of extreme discomfort. It is a supportive touch, a "*lifeline,*" providing patients with courage, the power to overcome fear (Tillich, 1952/1977), and the strength to "hold on," to "*cope,*" to "*get through*" these most painful of situations.

Although the modes of direct touch referred to above are considered to be the most compelling forms of "pathic" contact with patients (Gadow, 1984; van Manen, 1999), the comment by one of the critical care nurses in the excerpts above also implicates and supports the value of eye contact, a kind of "touching at a distance" (Montagu, 1986, p. 124), as an alternate means to supportively and comfortingly keep "in touch" with patients during painful treatments and procedures, particularly when direct touch is not possible or sustainable. However, more important perhaps is the notion that, whatever the tactic, any attempt by nurses to remain affectively ("pathically") connected to, and supportively involved with, critically ill patients during such painful situations helps to make such situations bearable and is what differentiates any act of inflicted pain from the unbearable and de-humanizing act of torture (Schroeder, 1992).

Simultaneously, this establishment of pathic eye contact, which is inherently intersubjective, also provides nurses with a means to truly "see" patients, to sense how well they are tolerating such painful treatments and procedures, and to determine whether or not additional or alternate strategies to minimize dis-comfort are called for. For example, in the face of severe distress, nurses may respond by administering additional pain medication, slowing the tempo of the procedure, or advocating for some "*time out*"—some time to rest, some space to breathe.

Unfortunately, the critical illness experience for many patients entails episodes of intense recurrent bodily pain or the need to repeatedly undergo certain intensely painful treatments or procedures. Accordingly, such painful experiences can become dreadful experiences. Unlike the experience of "fear-as-worry" consequential to not knowing what is going to happen, these recurrent and intensely painful episodes and events often evoke the experience of "fear-as-dread" consequential to actually knowing what is going to happen. Yet, like "fear-as-worry," the longer the patient dwells or focuses on the pain (or its anticipation), the more dreadfully burdensome the painful experience becomes, thus making it much more difficult to bear. Yet as their stories and experiences reveal, critical care nurses may help to make such recurrent experiences of bodily pain more bearable for patients by using distraction in a way not unlike the way they use it with patients who are burdened by worry. For example, recall how several critical care nurses who decided to "*create a positive and jovial atmosphere*" by "clowning around" helped Bill, the patient who had undergone bilateral below-the-knee amputations, to "*get through*" the painful dressing changes on his graft sites. Or, for that matter, note the critical care nurse's comments below regarding how effective social conversation can be in achieving similar outcomes in those who must repeatedly endure painful burn dressing changes:

> *I talk to them while I'm doing their burn dressings. [I ask them] about their kids, about their life at home, about their plans, or if they have any concerns. Or I just talk about my own life. I get a little bit personal because you know some of their personal stuff and they often quiz you about yours. You find something in common, and you go with that. I play a fair amount of sports, so I'll often get into sports. So continually talking to them . . . sort of distracts them and they tend to tolerate it much better.*

Whatever the strategy used, whether it be humor, lightheartedness, or engaging patients in social conversation, distraction helps to divert patients' attention away from the pain to something far less traumatic and thus minimizes their sense of vulnerability (Morse et al., 1994), helps them to relax and, in turn, ameliorates their pain to the point of making their immediate experiences more bearable. As for the impact of distraction on the sense of dread that may fill the interval between painful episodes or events, one can surmise that, with its use, the memory of the painful experience would also be rendered less traumatic and therefore free up some room for something else in the patient's world (Bergsma & Thomasma, 1982; Bottorff, 1991) or simply provide for a much-needed interlude.

While much of the recent description above has focused on the valiant efforts of nurses in conquering bodily pain arising from the major and most obvious of sources, the comments and stories of nurses also attest to their ability to minimize many other forms of bodily dis-comfort, most notably those that may discreetly arise from the simplest of procedures or the most subtle of circumstances. With experience, nurses develop knowledge of a sensitive kind in which they become sensitively aware of the general impact of certain activities on their patients and thus respond accordingly to avoid or minimize dis-comfort. For example, by anticipating the pain involved in moving a patient, the nurse ever so gently and unhurriedly helps the patient to a new position, finding just the right spot to place his or her support while often adding the reassuring comment that, contrary to the fear of many patients, he or she will not fall off the side of the bed. Likewise, as nurses become "pathically," affectively, or intersubjectively involved with their patients, this connectedness opens them up to patients' experiences in such a way that they can truly "see" and "feel" something of their patients' discomfort (Leder, 1990), sometimes, amazingly enough, even before the dis-comfort has been fully revealed to their patients (van Manen, 1998). Thus, having embodied this dis-comfort and actualizing a "one-body" state (Leder, 1990, p. 163), a "compathetic" (Morse, 2000; Morse & Mitcham, 1997) or sympathic physical state, the nurse initiates an appropriate compassionate or "compathetic" response. For example, how often has a nurse been overheard to say, sometimes for no apparent reason, that a particular patient "doesn't look comfortable" and then, without hesitation, responsively and effectively repositions a neck, raises or lowers the head of the bed, shifts a limb, adds a roll, fluffs a pillow, adjusts a tube, rearranges a line, smoothes a sheet, applies a lubricant, places a cool cloth, massages a foot, rubs a back, spreads a warm blanket, loosens the bedding, fetches a drink, replaces soiled tape, turns down the alarms, dims the lights, pulls the curtains, shuts the door, and so forth.

Undoubtedly, it was this "one-body" compassion (Leder, 1990, p. 163), along with her reflection on *"the simple everyday things [such as comfort measures] that we take for granted in everyday life"* but cannot when we are critically ill or injured, that likely prompted Tammy's nurse to lend her able body to carry out the hair wash that Tammy's cast- and pain-encumbered body was unable to. Sensing Tammy's uncomfortable predicament, she felt that, by getting rid of the dirt, grit, glass, and blood that had itchingly dried in Tammy's hair since the car accident several days earlier, she could "*make her [Tammy] feel more like herself.*" Even if this familiar feeling lasted only temporarily, she felt that it would still be worthwhile, that it would still be of some consequence. Likewise, it was probably this same sort of bodily attunement (Cameron, 1998) to Tammy's threshold and tolerance for pain that subsequently helped to control the pace of her actions so as to keep the other discomforts (e.g., bodily pain) associated with Tammy's underlying injuries at bay while she sensitively, gently, and care-fully shampooed Tammy's hair for her. This is how she described her triumph on that particular day:

> *She [Tammy] just loved it—the scalp massage, the smell of the shampoo, and the brushing of her hair afterward. She kind of reminded me of a dog who had just been scratched on the belly or behind the ears—totally content.*

By fulfilling Tammy's pleading desire in a very sensuous and soothing way, she helped Tammy to feel refreshingly more akin to her comfortable embodied self and, for the time being, "*totally content*"—filled with, absorbed into, and possessed by a state of contentment (Buytendijk, 1973). The word content derives etymologically from the Latin *contentus*, which means 'satisfied' (Onions, 1966), and reflects a state in which one's desire is met, leaving one at ease, unworried, untroubled, tranquil, or serene. And in addition to feeling justifiably proud of her feat, unwittingly Tammy's nurse no doubt felt "*totally content*" too!

Assuaging Alienation

"In . . . relationship with another, the detached and estranged self can find reconnection" (Younger, 1995, p. 67).

"It is the privilege of those who care for the suffering to show them that they are not thereby excluded from the human community" (Younger, 1995, p. 71).

"The presence of others. . . [is what often] makes the experience [of critical illness] bearable" (Parker, 1999, 69).

Marcel (1962) claims that "all captivity partakes of the nature of alienation" (p. 30). And as suggested by Buytendijk (as cited in Leder, 1990), the captivity of critical illness is no exception. The alienation that is precipitated by the experience of critical illness and the suffering that ensues encompasses alienation from the self, others, and, among believers, one's God (Burkhardt & Nagai-Jacobson, 2002)—potentially, one's entire world. Yet one wonders how this alienation comes to be. And how is it experienced by those so afflicted?

Now, as captive, the critically ill patient's world shrinks. His or her horizon suddenly narrows to the bed that he or she occupies and the people who move in and out of his or her field of vision (Hawley, 2000a). Now bodily connected to technology that aims to monitor and support physiological life, the critically ill patient, ironically, becomes disconnected from his or her everyday life. A once familiar world of meaningful things, events, and people "now echoes as though from an inaccessible distance" (Leder, 1990, p. 81), often leaving the patient feeling isolated, estranged, detached, cut off, and more often than not, profoundly lonely and alone, feelings that may be magnified by an inability to speak, motor or sensory incapacity, bewilderment, altering states of awareness, separation from family and friends by actual distance or because of others' (e.g., care providers) conformity to established practices and policies, and so on.

In addition to the obvious circumstances that tend to accentuate the experience of alienation, other less obvious "alienating" circumstances may also exist—specifically, those that ultimately keep others at a distance. For example, a critically ill patient who is feeling overburdened by a new and frightening reality may withdraw or retreat into the self in an attempt to escape a plight that is seemingly unbearable (Bergsma & Thomasma, 1982; Dewar & Morse, 1995). Yet, ironically, by alienating the self, the patient actually risks increased isolation, further estrangement, and deeper loneliness as he or she essentially barricades the possibility of support from willing, yet unsuspecting, others.

Similar consequences may also result when others seek to avoid a critically ill patient in response to certain behaviors that they unwittingly misinterpret as being solely offensive rather than as what is an indirect attempt by the patient to escape some of the alienation that accompanies the captivity of critical illness. The anecdote about Philip is a case in point. For a time, when Philip was achingly alone in his fear, his attempt to escape the alienation of his suffering predicament was not only met with defeat, but, ironically, with more intense alienation as he suddenly found himself being avoided by others and without "*anyone to talk to,*" or perhaps more aptly put, no one willing to "listen."

Likewise, perhaps because of heightened vulnerability or fear, others remain disengaged from the critically ill patient or engage in such behaviors as offering false reassurance or uttering clichés that, despite being well intentioned, only serve to silence the patient and keep others distant. Regardless of the underlying circumstances, however, any situation in which others remain distant not only leaves the patient feeling ever so isolated, estranged, and lonely, but perhaps also feeling like a lone soldier battling alone—abandoned, deserted, or forsaken at a time of great need, a feeling that, according to Younger (1995), characterizes the "utmost" alienation.

Although I acknowledge that some form, intensity, and duration of alienation is an intrinsically burdensome aspect of the experience of critical illness and critical care and indeed, as intimated above, may even be perpetuated by critical care nurses, among others, the experiential accounts of these critical care nurses demonstrate that critical care nurses are equally capable of assuaging alienation, and in so doing can make critically ill patients' experiences of critical illness more bearable. Yet one wonders how critical care nurses assuage alienation in critically ill patients. What nursing actions and interactions are considered crucial? In what ways are they beneficial? What difference does it make for critically ill patients when nurses' spirited efforts to assuage alienation are ultimately successful?

As their experiences and stories indicate, the actions and interactions that critical care nurses use to assuage alienation in the critically ill primarily fall into two broad categories: namely, those that help to create and maintain a connection between the patient and the nurse and those that help to preserve the critically ill patient's preexisting connections with important others, which, for some, also includes a connection with one's God. Accordingly, it is within these categories, respectively, that I will describe the crucial actions and interactions that critical care nurses use to successfully assuage alienation in the critically ill.

Critical care nurses create and maintain connections with critically ill patients by talking, listening, and touching, either independently or in various combinations, depending on the critically ill patient's unique situation (e.g., ability to speak, level of awareness, amount of distress, or type and intensity of alienation) and other contextual factors. Without making any attempt to be comprehensive, I offer a few straightforward examples below.

Talking about everyday topics, from arts and entertainment to the weather and world events, can be an effective means of creating and maintaining a sense of "everyday" connectedness or "shared humanity" (Nichols, 1995, p. 34) in patients who are alert and not acutely distressed as well as a means of keeping them connected or "in touch" with the outside world. Listening in a sensitive and observing manner with the intent of gaining a sympathic or engaged understanding of patients' inner experiences can be an important means of establishing and maintaining a deeper sense of connectedness that derives from simply being listened to, from merely being understood, from purely having another bearing witness to one's inner experience. Recall again the encounter between Philip and his nurse in which her understanding alone breached his feeling of being alone. Not unlike a time when you confided your fears to an old friend who "really" listened and "truly" understood, Philip's nurse forged a moment of closeness, togetherness, or oneness that without which would surely have kept him burdened in isolation.

Likewise, through the use of touch, a patient may discover that he or she is not alone. Whether in the form of a tender caress, a gentle stroke, a clasping of hands, a soothing massage, or a simple embrace, touch is "the embodiment of a 'pathic' contact" (van den Berg, 1966, p. 127). It represent an expression of the nurse's participation in the patient's experience (Gadow, 1984) and thus is deeply intersubjective (Kleiman, 2005; van Manen, 1999). Through "pathic" touch the patient feels not only the bodily presence of the nurse, but also the presence of the self of the nurse whose genuine intent it is to care—to "be with" the patient, to share the patient's experience, and to support and comfort. And perhaps nowhere is this power of touch more fully and poignantly revealed than when it is used in those critically ill patients who are facing imminent death, abandoned, afraid, and alone. The anecdote in which Mrs. White's nurse describes the experience of "*being there for her*" as she was dying provides one such example.

Recall that Mrs. White was the elderly woman who had had extensive bowel surgery and whose condition had subsequently deteriorated to the point that, even with surgery, recovery was no longer an achievable goal. In light of this prognosis the family was contacted and following their arrival gave permission to withdraw her from life support—to turn off the inotropic medications and to extubate her. Shortly thereafter, they left. While still aware enough to notice her family's absence, she became restless. And although she was not talking, her eyes forebodingly posed the question, "Where's my family?" In response, the nurse "*stroked her head*" and "*held her hand.*" She "*tried to explain to her that, even though her family was not there,*" she "*was there.*"

Mrs. White's nurse was not surprised by this family abandonment. Yet it was this still "incomprehensible betrayal" (Montagu, 1986, p. 343) that made it all the more clear to her what her ultimate mission was—to accompany Mrs. White "at least part of the way along . . . [her] lonely and frightening road" (Cassidy; as cited in Zerwekh, 1993, p. 26). She, like Echo Heron (1994), had been witness to the needs of the dying and had long ago been convinced that no one should die alone, in pain, or without peace. And thus, after removing Mrs. White from life support and sedating her appropriately, she "took on no other task than being there" (von Post & Eriksson, 1999, p. 984), "being there" connoting a "being with," a living personal presence. And for that, all she really needed was her touch. Words would not do. Mrs. White did not need answers. She needed human presence—someone to be there so that she did not die alone, someone to "be with" her as she journeyed toward her life's last milestone.

Although situations like Mrs. White's are shockingly real, by all accounts they are "the exception rather than the rule," so to speak. In most cases critically ill patients have any number of meaningful and supportive connections with family members and others that, when preserved, provide an invaluable means of assuaging alienation and, in turn, help them to bear, to endure, to "*get through*" the burdensome experience of critical illness. Being privy to such knowledge, nurses encourage and facilitate the immediate presence and participation (i.e., direct involvement in certain aspects of care) of those with whom patients have established meaningful and supportive connections, even if it sometimes involves "*bending the rules,*" "*going the extra mile,*" and in some cases permitting and accommodating "unconventional" visitors (e.g., a pet, a newborn, or the just-married couple). And in the event that, for whatever reason, the actual physical presence of close supportive others is not possible or viable, nurses also avail themselves of other means to keep critically ill patients tied to those with whom they have close ties. Whether it is by arranging and maintaining telephone contact, by evoking thoughts and memories of them through social conversation, or by securing such items as photos, other memorabilia, or "things from home" (Bottorff, 1991, p. 249) that can serve as reminders of these secure connections, all embody a kind of "presence-in-absence" (Sandelowski, 2000, p. 85), as it were, the power and meaning of which many a nurse bears witness when, for example, a critically ill patient's face lights up or his or her voice lifts upon the receipt of a call from home or the mention of a special grandchild, a loving spouse, a cherished friend, or a pet who has been a long and faithful companion (Burkhardt & Nagai- Jacobson, 2002).

Likewise, nurses also assuage critically ill patients' alienation by incorporating or accommodating elements of meaningful secular and, where fitting, sacred rituals marking ordinary or significant events into their care. Whether they are celebratory (e.g., a birthday, engagement, sports victory, or Christmas) or ceremonial (e.g., prayer, sweet grass, or other spiritual ceremonies) in nature, such rituals provide an important means through which patients can maintain a sense of connectedness to their familiar worlds and to the important others within them, including, for many, a sense of connectedness to God (Burkhardt & Nagai-Jacobson, 2002) as well as a means by which they also experience the signifying presence of supportive others.

Making the Life Threatening Life Sustaining

Critical care nurses are "the guardians of life." (Heron, 1994, p. 295)

"The reason our patients survive to the end of the day is because we are there—just the fact that we showed up and brought our talents with us."

The sustenance of the body's life is dependent on maintaining stability, balance, equilibrium, or "homeostasis" of function in what is a very complex interrelated physiological system. In the healthy, stable physiological function is automatically, instantaneously, and independently maintained by the body itself. However, in the critically ill, the presence of life-threatening disease, injury, or complications either from the underlying disease or injury itself or, ironically, from its diagnosis and treatment tips or threatens to tip this physiological balance beyond the body's control, leaving the lives of the critically ill hanging in a precarious balance (Cameron, 2002) while the enemy of death threatens to take over, to seize, their lives.

In their experiential accounts critical care nurses readily acknowledged that despite heroic efforts some critically ill patients inevitably succumb to their diseases or injuries, or indeed to any number or variety of complications. As one critical care nurse expressed it: "*Some [patients] die no matter what you do or how hard you try.*" Yet at the same time their experiences and stories attest to their abilities to make a difference by sustaining the lives of many others who are, or may be, at risk of encountering unstable, perilous, critical, or life-threatening situations. As the "guardians of life" (Heron, 1994, p. 295), critical care nurses act and react in many ways, often instantaneously, to attain or maintain stable physiological functioning, to prevent undesirable or destabilizing physiological change, or to rescue the critically ill from the grip of death in the event of physiological crisis.

Attending Vigilantly

"A careful nurse will keep a constant watch over her sick" (Nightingale, 1859/1992, p. 11).

In dwelling upon the vital importance of "sound" observation, it must never be lost sight of what observation is for. It is not for the sake of piling up miscellaneous information or curious facts, but for the sake of saving life and increasing health and comfort. (Nightingale, 1859/1992, p. 70)

It is unlikely that the statement above regarding the importance of "sound" observation made by Nightingale well over a century ago would be refuted by any of the nurses practicing in the critical care units of today. Indeed, the comments of several critical care nurses reflect very similar sentiments:

> *A nurse's assessment is one of the things that makes the most difference because you catch things early on—before things get out of control or before the patient gets into trouble; for example, codes.*
>
> *Because you're seeing your patient on a continuous basis you're able to, if they're starting to go into, say, [heart] failure, you're able to pick up on the*

> *signs, the first signs that you see, and maybe you're able to prevent it from going too far.*
>
> *When you're on top of things and find things before they harm the patient, it's very satisfying. We're really saving lives often.*
>
> *We know way more than the doctors when it comes to how our patients are reacting to what we're doing, what their [the patients'] overall condition is at any given time, because they're [the doctors are] not there and we are. So, you know, we're on top of things all the time and can catch something before it turns into a crisis, before it's gone too far and it takes loads to correct it.*

As the soldiers in the trenches, on the front lines, fighting the day-to-day battle against the enemy, critical care nurses remain constantly "on guard"—continually attentive and vigilant and ready to respond appropriately, swiftly, and deftly in the event of danger, distress, or deterioration in the physiological functioning of their critically ill patients. They know that critical and life-threatening change may occur "in a flash" and without warning. And thus, at no time do they want to be "caught off guard." Yet what guides their vigilance? And what does it entail?

"*The nurse knows what to look for.*" While this statement from a critical care nurse may suggest that vigilance is guided by simply knowing what to look for, knowing what to look for is not as simple as it looks. At its best, vigilance requires a sound and integrated knowledge base composed of theoretical (scientific) knowledge learned through study (e.g., pathophysiology, clinical manifestations, diagnosis, treatment, and potential complications), practical knowledge gained from experience (e.g., typical clinical trajectories or "the normal course of events" and known risks or complications in specific patient populations and subpopulations), and particular knowledge of the patient, including the clinical facts (e.g., co-morbidity or co-existing diseases and injuries) and knowledge of the patient as person (Jenny & Logan, 1992; Tanner et al., 1993).

For example, knowing the expected signs of, and time frames for, progress sets up the possibility for critical care nurses to promptly recognize the unexpected, the incongruous, or the absent (Benner et al., 1999). Similarly, knowing any potential risks or complications makes it possible for them to not only better prepare themselves for what might be needed to respond to any such eventuality, but also better able to detect the early crucial warning signs of onset. As the old saying goes, "Forewarned is forearmed."

Vigilance constitutes an ongoing sensory or perceptual activity that involves engagement of the nurse's bodily senses. As one critical care nurse described it, vigilance presupposes "*a level of awareness that we aren't aware of that is in tune with everything,*" a kind of "unaware awareness" (van Manen, 1998, p. 11), so to speak, yet it can suddenly heighten and "*zoom toward,*" and zero in on, anything untoward, like a kind of bodily radar, perhaps. Vigilance entails watching with a trained eye, listening with a tuned ear, touching with a practiced hand, and smelling with a sensitized nose, the purpose of which is to ongoingly gather information about the critically ill patient's physiological functioning while remaining alert for any signs indicative or warning of undesirable or destabilizing change. And while vigilance also includes the continuous scrutiny of technology for the pieces of information it provides by extending one's ability to "see and hear beyond . . . given range" (Tisdale, 1986a, p. 430), critical care nurses are candid about its allure and caution against total reliance on it for information about the actual condition of the patient. The following are the remarks of a few:

> *You never just depend on the machines and what they say. To get clinical information about the patient, you have to look at the patient.*
>
> *The patient is really your focal point, not the machines.*

> *The machines don't have all the answers. You have to look at the patient.*
>
> *They [the machines] give you numbers [and] waveforms, but they can't tell you if the patient is in pain. You have to get to the patient. You have to "see" the patient. You have to use your clinical skills. I tend to rely more on what I see, hear, [and] feel, that sort of thing. At the same time I don't ignore the machines. They're my back-up. I put the two together, but I think the clinical part of it probably weighs a little bit more heavily than the other.*

Aside from the fact that the images, numbers, and waveforms produced by technology don't provide "*the total picture,*" and indeed at times may even be spurious or aberrant, what is perhaps most noteworthy is that, by being vigilant, critical care nurses are often able to "*pick up on*" the early and subtle signs of deteriorating change before any corresponding change is detected in the numbers or on the screens. Moreover, they also have an uncanny ability to "sense" a change in a critically ill patient's condition (van Manen, 1998) or to "feel" when something is not quite right, even if they themselves cannot explain it, "*verbalize*" it, or "*put a finger on it.*" Critical care nurses commonly refer to these perceptions as "*gut feelings,*" and along with their ability to recognize "*things*" (as in concrete evidence of change) early, credit them for spurring further investigation or prompting appropriate and timely action that ultimately proves beneficial in reversing deterioration, preventing complications, averting crisis, or, indeed, saving lives. In claiming legitimacy for "*gut feelings,*" one critical care nurse commented, "*Your gut feelings tell you to act on something or at least to check something out. I have learned to listen to mine; they're never wrong.*" Another said:

> *We're there and we see things, [and] if something isn't quite right, you know it. Even if you can't put your finger on it, at least you can start saying [to the physicians], "Look! Something's not right here. We need to be looking at*

> *whatever." . . . I often rely on my gut feelings. . . . Sometimes that's all I've got [to go on], and usually I'm right!*

Apprehending Astutely

"The body becomes the object of an ongoing interpretive quest" (Leder, 1990, p. 78).

"[The nurse] puts so many multivariate pieces of information together instantly and knows" (Cameron, 1998, p. 140).

> *Not only do you assess; . . . you actually have the knowledge to realize what findings in your assessment are important. You learn quickly what is important and what isn't. You know what to weed out and what to act on.*

For critical care nurses, an abundance of information concerning patients' physiological functioning not only becomes the object of perception, but also the object of interpretation. As particular and particularly complex patient situations rapidly evolve, critical care nurses keep track. And by staying "*on top of things,*" they are often able to gain immediate insight; that is, to grasp, to understand, to comprehend, or to interpret the meaning and significance of any apparent changes in physiological functioning, or indeed any subtle warning signs of change (e.g., an atypical trajectory, bodily changes in color, temperature, appearance, decreasing level of consciousness, increasing restlessness, or an unusual response to a drug) without conscious reasoning (Benner et al., 1999; Benner et al., 1996). In other words, they are often able to directly apprehend the meaning and significance of the patient's current situation in its particular context; that is, in relation to the patient's situation as a whole, including the immediate past and the foreseeable future. Benner et al. (1996) describe this direct apprehension of a patient's particular situation as intuition (L. *intueri*, which means 'to see within') and suggested that experience, knowing the patient, and engagement with the patient facilitate the intuitive experience.

Critical care nurses commonly describe the activity of apprehending as one of "*putting the picture together.*" In doing so, they recognize what is salient, relevant, and qualitatively distinct in the particular patient situation (Benner & Tanner, 1987; Benner, Tanner, & Chesla, 1992; Benner et al., 1999; Benner et al., 1996; Benner & Wrubel, 1982). And guided by their apprehension of the patient's particular situation, they make solid decisions and take appropriate action—immediately if the situation calls for it. Such was the case in Mr. Evan's situation.

Recall that Mr. Evans was the gentleman in his 50s, married, with grown children, who arrived in the neurosurgical intensive care unit (NICU) following a standard craniotomy for the removal of a tumor and had a grand mal seizure while in the recovery room. During his initial post-op assessment in the NICU, his nurse discovered that he was hemiparetic. Otherwise, his post-op condition was essentially "stable." His nurse recounted that "*he was awake—a little drowsy but no more that you would expect considering the anesthetic. . . . His pupils were fine. He was oriented. He answered . . . my questions appropriately and talked to his wife.*"

The resident surgeon discharged him from the recovery room, believing "*that the seizure was just an isolated incident related to the location of the surgery.*" "*He figured that Mr. Evans was hemiparetic because he was postictal*" and post anesthesia. Yet in her wisdom, Mr. Evans's nurse "*knew there was something more wrong with him.*" As she explained, "*He wasn't your typical groggy, postictal patient.*" Given the circumstances (i.e., he was recovering from anesthesia), "*he was quite awake.*" Yet over a brief period of time he had not become any stronger but he had become a little groggier—an incongruous finding. She was certain that her "*patient needed attention!*" She argued to no avail that if indeed he was postictal, his level of consciousness should have been improving, not deteriorating. Meanwhile, his hemiparesis was not improving either. Just as she was about to go up the chain of command to report her concern to the chief resident, the staff man miraculously phoned. Once apprised of the situation, he immediately went down to the unit to see Mr. Evans and subsequently ordered a CT scan. The CT scan revealed that Mr. Evans had sustained a huge life-threatening epidural bleed consequent to an inadvertent nick of an artery during surgery and thus had to undergo emergency surgery. Had his nurse not been completely confident in her judgment and persistent enough to follow up on her astute grasp of the situation, the outcome for Mr. Evans could have been very grave rather than what was, in his nurse's words, "*a good save.*"

There are perhaps several "salient" aspects in this anecdote about Mr. Evans. First, knowing the typical presentation of a patient in the immediate post-op period following a standard craniotomy, Mr. Evans's nurse intuited a problem when she noted his hemiparesis—an abnormal, unexpected, and thus significant (salient) finding. Second, although Mr. Evans was drowsy, she noted that his drowsiness was qualitatively distinct from, and incongruent with, what one would typically expect in a postictal patient. And finally, her intuition, confidence, and determination, well honed by experience, enabled her to appropriately secure lifesaving medical attention for Mr. Evans "in the nick of time."

Acting Skillfully

"The artful nurse knows more than what is to be done; she knows 'how to do it.'" (Nightingale; as cited in Johnson, 1994, p. 7).

Critical care nurses' success in sustaining the lives of many of the critically ill is undoubtedly attributable to the fact that they are vigilantly attentive, that they perceive and astutely apprehend the meaning and significance of any undesirable or destabilizing change in patients' physiological functioning, and perhaps most important, as Nightingale purported in the above quotation, they "know" not only "what is to be done," but also "how to do it." In other words, they know how to act skillfully to attain or maintain stable and optimal physiological functioning in their critically ill patients in ongoing and often rapidly changing situations. Yet in the context of sustaining life, what does this skillful action—action full of skill—encompass? And what makes it possible?

As revealed in their experiences and stories, critical care nurses know how to skillfully perform "vital" and complex psychomotor skills (e.g., intravenous line and urinary catheter insertion, nasogastric intubation, endotracheal tube suctioning, phlebotomy, CPR, defibrillation, and so forth) quickly, proficiently, and safely. They know how to skillfully manage multiple, simultaneous life-sustaining technological and pharmacological interventions (e.g., intravenous drips, mechanical ventilators, pacemakers, chest tubes, dialysis, intra-aortic balloon pumps). They know how to skillfully respond to significant and often sudden fluctuations in physiologic conditions (e.g., body temperature, fluid balance, electrolyte balance, pH, intracranial pressure, hemodynamics, and oxygenation). And they know how to skillfully assist patients in becoming self-sustaining (Benner et al., 1999)—that is, independent of life-sustaining technological and pharmacological interventions—without destabilizing (e.g., weaning from mechanical ventilation, weaning from vasoactive drugs, or deballooning).

Skillful action is, in large part, the result of skill mastery, a process that Leder (1990) referred to as incorporation. Etymologically, incorporation, derived from the Latin *corpus*, which means body, literally means 'bringing within a body,' and thus a skill is finally mastered when it permeates one's body (p. 31)—when it becomes embodied. Whereas in the initial stages of mastering a skill one notes all of the relevant aspects and pays attention to certain rules of performance, with mastery the skill can be carried out "without conscious effort, allowing . . . [one's] focus to be directed elsewhere" (p. 31). Consider, for example, as others (Benner et al., 1996) have suggested, the skill of driving a car. Having mastered the skill, the driver no longer concentrates on changing gears, adjusting speed or distance, maneuvering turns, accelerating, breaking, or signaling, but rather focuses on going somewhere and getting their safely. In the case of skill mastery in critical situations, the critical care nurse subconsciously manipulates, handles, and controls the technology while remaining attentive, intuitive, and responsive to the patient and the patient's physiological responses. And thus, in the end, skill mastery not only frees critical care nurses from thinking about "how" to do something, it also allows them to maintain the level of attunement or awareness needed to ongoingly perceive, interpret, and know "what" to do next to attain or maintain stable and optimal physiological functioning in their critically ill patients. For example, by recalling the anecdote in which the senior nurse took some time to coach the novice nurse as she was attempting to wean her neurosurgical patient off the vasoactive drugs Epinephrine and Levophed, you can no doubt sense how important each of these elements are to the overall success of such an endeavor as well as appreciate the knowledge and experience that operate in the background.

Making the Unliveable Liveable

> "[Nurses cover] the unliveableness of . . . [lived life] with relation and skill; they assist patients to recover themselves, to reinsert themselves back into their lived world again. They make . . . [lived life] and their bodies liveable again" (Cameron, 1998, p. 185).

"What happens when . . . [the] body breaks down happens not just to that body but also to . . . [the] life which is lived in that body? When the body breaks down, so does the life" (Frank, 1991, p. 8).

In the presence of life-threatening disease or injury, as one's critically afflicted body suddenly loses its silent, taken-for-granted nature and obtrusively forces its way into one's awareness (Bleeker & Mulderij, 1992; Leder, 1990; Merleau-Ponty, 1962; van Manen, 1998), one's life (i.e., lived life), one's world, one's whole existence undergoes sudden, profound, and often irrevocable change. No aspect remains untouched (Frank, 1991). Life as lived becomes difficult, cumbersome, laborious, restricted, unmanageable—essentially unliveable.

Rather than being the willing instrument for the things that one wants to do, one's critically afflicted body now manifests itself as an obstacle to the things that one wants to do (Bleeker & Mulderij, 1992; Olson, 1993; Pellegrino, 1985). Now as the conscious object of one's attention, it stands in the way of, or disrupts, one's normal engagement in the world. Dis-embodiment usurps embodiment. Now beyond one's control, bodily distrust supersedes trust. Now with its physical stamina diminished and its embodied capabilities compromised, dis-ability exceeds ability. Now unreliable, one must rely on others to do what one can no longer reliably do. Dependence overthrows independence. Now with much of one's daily existence in others' hands, one becomes subject to others' commands. No longer in control, one may begin to question whether one still plays any useful role. Impotency supplants potency.

In the captivity of critically illness and critical care, one's familiar existence now happens at a great distance, beyond the horizon of a now shrunken world (van den Berg, 1966). And instead of "reaching out to what comes next" (van Kaam, 1959, p. 1709), one now lives mainly in a confined present with "plans disrupted and possibilities withheld" (Rawlinson, 1982, p. 75). The long-term future is contingent, unforeseeable, or unpredictable—one is now uncertain, hesitant, wary about what is in store.

Meanwhile, one may be confronted by a long recovery trajectory (e.g., massive trauma, organ transplant), multiple surgeries (e.g., skin grafting), major setbacks (e.g., unsuccessful weaning, dysrhythmias, sepsis, organ failure, hemorrhage), debilitating pain or other ailments, or the stark reality that some form and degree of disability or disfigurement is permanent, any of which may have a "dispiriting effect" (Pettigrew, 1990, p. 504), leaving one feeling discouraged, disheartened, or depressed. While under the spell of such dark and gloomy moods (Bollnow, 1989a), all seems lost. Hope may fade into a sense of despair (L. *desperare*, which means 'without hope'). Vitality may wither into a sense of defeat. Life's meaning and purpose, life's worth, may dwindle to a sense of emptiness. In response, one may become passive, apathetic, despondent, or withdrawn, and perhaps ready to abandon the fight as life seems lifeless and the future bleak.

While relating their experiential accounts, critical care nurses attested to the unliveableness of life-disrupting critical illness and its associated care. Yet, concurrently, their experiences and stories attest to their abilities to make a difference by making the unliveable as liveable as possible. In various ways, critical care nurses act and interact to help patients to recover liveable relations with their bodies and their worlds such that the silent, taken-for-granted experience of the body and their normal engagement in the world are restored again as much as possible (Bleeker & Mulderij, 1992; Bottorff, 1991; Morse et al. 1994, 1995; van Manen, 1998). Like the healthy, the critically ill need to be able to forget their bodies—to recover a self-forgetful state (a.k.a., the state of embodied wholeness)—and to reconnect to the world again, despite changed realities and all the constraints, limitations, encumbrances, and challenges that such change may impose (Bleeker & Mulderij, 1992; van Manen, 1998).

Fostering Normalcy

"From one day to the next, the nurse participates in and often initiates the small changes which aid recovery" (Olson, 1993, p. 149).

Regardless of the nature of the underlying disease or injury, recovery from critical illness, to which I alluded in the section above, entails "the re-establishment of relationships" (van Manen, 1999, p. 31)—critically ill patients' relationships with their bodies and their worlds. Accordingly, recovery is deemed to be primarily a restorative or "reparative" (Nightingale, 1859/1992, p. 6) process—a healing (OE. *hælan*, which means 'to make whole') process—that typically occurs over a period of time and predominately after the critical, life-threatening nature of the patient's condition has stabilized.

As such, critically ill patients rarely achieve recovery in its absolute sense during their stay in the critical care unit. For those patients who experience episodic events (e.g., myocardial infarction, emergency surgery) and are transferred to an acute care unit within a matter of days, a short time frame is probably their biggest obstacle to achieving, in relative terms, a "full" recovery. For example, there is little chance for their bodies to completely mend, for them to "make sense" of their ordeals, or for them to learn to live with, adapt to, and accept any life changes that may have been imposed on them. And for those who for various reasons become longer-term patients often requiring continued technological support (e.g., mechanical ventilation, dialysis, ventricular assist devices) or other high-intensity interventions, it is perhaps the complexity of their needs more so than the time frame that becomes the major obstacle. Depletion of physical reserves, physical deconditioning (e.g., loss of muscle strength and mass), and increased vulnerability to a host of complications can certainly complicate matters for them, not to mention the fact that, in the aftermath, many (e.g., the victims of trauma) also have extensive "rehabilitative" needs that cannot be adequately met given the scope of practice in the critical care unit (Crooks & Clochesy, 2001). Notwithstanding, the efforts of critical care nurses to foster normalcy go a long way to helping critically ill patients get "*on the road to recovery*" and thus well on their way to reestablishing more liveable relations with their bodies and their worlds. Yet one wonders how critical care nurses foster normalcy in their critically ill patients. What does this fostering of normalcy involve? And experientially, in what ways does it help critically ill patients' recovery to evolve?

One of the most fundamental ways that critical care nurses foster normalcy is by reincorporating patients' daily routines, rituals, and practices into their lives. For example, as one critical care nurse explained: "*After sedation, paralysis, or just severe illness, [we] try to bring them [patients] back to normal by incorporating their daily life activities into the ICU, . . . getting them up, getting them to eat, and things like that.*" In so doing there is much to be gained or, perhaps more aptly put, regained. Such was the case for Ernie, the 70-year-old gentleman with chronic obstructive pulmonary disease. Although Ernie is not representative of the majority of critically ill patients, his story certainly represents some of the deeper dimensions of having patients resume or partake in customary activities, particularly those that involve some degree of physical activity that is not medically contraindicated.

Recall that Ernie had been in the critical care unit, trached and ventilated, for three months, during which time he had not been out of bed, not even up into a Geri chair. Like other unstable patients who require mechanical ventilation, Ernie was initially forced into immobility and essentially assigned a passive, dependent role (Bergsma & Thomasma, 1982). Physical contact with his surroundings and indeed his own body became limited, distancing him from each (Bergsma & Thomasma, 1982). Not surprisingly, after three months of "*not doing much other than helping to turn in bed, his affect was flat; he was down and out*." And true to the old adage "You lose what you don't use," he had also become debilitated from the inactivity that had deconditioned his body.

With Ernie's critical event stabilized and his weaning from the ventilator begun, his nurse sensed that it was indeed time he start "getting on his feet," literally and figuratively! And given her knowledge and experience with similar patients, she was certain that, by taking things "one step at a time," so to speak, he would eventually be able to stand up and walk on his own again. No way was she going to give up on him! In fact, she had a strategic plan for him.

In addition to knowing what would best promote his recovery, she also had a sense of "good timing" about his recovery. As Paterson and Zderad (1976) suggest, nurses and patients share not only clock time, but also lived time, which enables nurses to "*just know*" when certain opportunities coincide with patients' abilities. Thus Ernie's nurse was able to seize several opportune moments that helped him to achieve the progress that only such "moments of opportunity" could have provided.

One particular day she proposed getting him up into the Geri chair and during his plugging trial taking him outside for a "*suntan.*" And like many critically ill patients who have misgivings about their strength and their ability to stand again after prolonged confinement (Bergsma & Thomasma, 1982), Ernie was somewhat hesitant. Yet his nurse's unwavering belief in his ability seemed to be enough to lure him into going along with her plan—a progressive plan that, accompanied by her "supportive commendation" (van Manen, 2002b, p. 35), heralded much success and future promise within a span of less than two weeks. Starting with that first day, she recalls:

> *He was just shocked that he could stand. . . . He eventually got to sit outside for about 10 minutes and go for a 20-minute jaunt in the Geri chair. . . . Because it was one of his first few days of plugging trials, he didn't last as long as he would have liked. But, oh, he saw the leaves blowing in the trees, and he enjoyed the breeze.*
>
> *After that day I noticed that his affect and stuff had brightened up. He opened up a lot more. Even though it took a bit of exertion, he talked more when he was plugged. He gave me a few high fives and wrote notes to me.*
>
> *Not even two weeks later, I got him out of bed and sat him in a regular chair. . . . He sat up for a whole hour and even took a couple of steps. . . . He realized he was a lot better at standing and pivoting. . . . I said, "See, I told you it would be hard when you first started. . . . It's still hard, but look at how much more you can do now than you could two weeks ago, not even two weeks. And if you keep up with your exercises, you'll be able to stand and walk on your own again." He looked at me with a mischievous grin and said, "Yes boss!" [Now], every time I'm nearby, he makes sure he lifts his legs and lifts his arms for me to see.*

As Bishop and Scudder (2001) remind us, nurses are "there to help patients recognize and realize their best selves, given their situation" (p. 77). Nurses are there to help patients overcome their fears and doubts and to help them regain the lost skills and abilities (or develop new ones) that they need to become what they have the potential to be (Hawley, 2000a). Although Ernie likely did not realize (as in fulfill) his full potential before being transferred out of the critical care unit, he did realize (as in notice) some of the gains he had made, small gains perhaps, but cumulative gains nonetheless, and the potential for more with continued exercise. And along with his recognized progress came a sense of eagerness that replaced his initial dubiousness. "Nothing breeds success like the experience of success," they say!

For Ernie and countless other critically ill patients, the seemingly inconsequential activities of getting out of bed, sitting up in a chair, walking a few steps, or performing a few simple tasks are indeed consequential. Not only do they help to increase patients' physical strength, stamina, and agility, but they also positively impact on patients' self-confidence, sense of efficacy, and vitality. And as patients slowly "learn how to live in their bodies again" (Bishop & Scudder, 2001, p. 55), they recover their earlier learned perceptions of space as well (Bergsma & Thomasma, 1982). Seeing and feeling their physical improvement renews their sense of bodily trust (Bergsma & Thomasma, 1982), stems feelings of helplessness and dependency, provides a source of pride that comes with personal achievement, and acts as a powerful motivator (Bleeker & Mulderij, 1992).

In an evocative personal account of recovering from a severe leg injury, Sacks (1984) offers further insight into the experiential benefits of increasing activity following a period of immobility as he describes the moment immediately following his first standing and walking after 18 days of being virtually motionless. No doubt certain aspects would also resonate with others who had endured similar experiences—patients such as Ernie perhaps! Sacks writes:

> Freedom! Now, suddenly, I could walk, I was free. . . . I found I felt completely different: no longer prostrate, passive-dependent, like a patient, but active, erect, able to face a new world—a real world, *a world now made*

> *possible*, instead of the shifting half-world of patienthood and confinement I had been in. I could stand up, step forward, go from and to—from confinement and patienthood to a real world, a real self, whose very existence, incredibly, and ominously, I had half forgotten. Stewing in confinement, passivity, immobility: stewing in the depths of scotoma and despair; stewing in the darkness of interminable night, I had forgotten, could no longer imagine, what daylight felt like. (pp. 123-124)

Yet what about those critically ill who, for various reasons, may be unable to mobilize themselves at this stage in their recovery, if ever? Are there options for them to again experience some sense of freedom, some sense of being a part of the real world, as Sacks (1984) alludes to?

Given the stories and experiences of several critical care nurses, one could argue yes. For example, by being taken outside for "*a little jaunt in the Geri chair*" or for a "*little outing*" in the wheelchair (as appropriate), the opportunity to experience the freeing feeling of moving with the wind, of having the sun on your back, or of hearing "the noise of a normal day going about its business" (Frank, 1991, p. 79) can provide the immobile patient (or mobile patient for that matter!) with both a taste of freedom and a feeling of being reconnected to the world again, both of which can in turn advance the patient's recovery in a stimulating and rejuvenating way.

Hitherto, the discussion related to critical care nurses' efforts to foster normalcy has primarily focused on incorporating "normal" activities into the patient's plan of care as a means of creating more normal situations that enhance the patient's recovery. Yet critical care nurses also provide such normalizing experiences for the patient by eliminating certain things as well; specifically, technologies and interventions that have outlived their usefulness (Benner et al., 1999), for example, low-flow oxygen and specialized beds, among other things, including those that may require a physician's directive. As Benner et al. (1999) remind us, "Technology dependence has great symbolic power to make the patient feel helpless and estranged from his or her everyday world" (p. 341), and thus continuation of those technologies and interventions that no longer serve any therapeutic purpose only serve to foster needless dependency while simultaneously impeding recovery and posing additional risks to the patient. Fortunately, countless critically ill patients have been able to make great strides in their recovery by virtue of the fact that their nurses "knew" that the time had come to eliminate those technologies and interventions that had lived out their intended purpose.

Although her long-term outcome is unknown, the anecdote about Mrs. Wong, the elderly Chinese lady who had had extensive bowel surgery, followed by pneumonia and renal failure, is illustrative. As a result of her nurse's "*three-day plan*" to get her extubated and out of a KCI bed, "*she eventually got out of the unit.*" And although her long-term prognosis was not good, she at least had been given the opportunity to be able to "*speak to her family again*" for however long. Given her situation, that feat, in itself, was certainly enough to make her life more liveable.

Engendering Hope

"We move into the future, therefore, to the degree that we have hope" (Lynch, 1965, p. 34).

"I see hope as the very heart of healing. For those who have hope, it may help some to live longer, and it will help all to live better" (Groopman, 2004, p. 212).

"By . . . [their] words and actions . . . [nurses] have the opportunity to offer hope and do it well" (Savett, 2003, p. 9).

"Although hope is considered to be an integral component of daily life" (Post-White, 2003, p. 10), it is invariably challenged (as in questioned) and perhaps even extinguished in the presence of critical illness, particularly when the critically ill confront distressing circumstances, discouraging setbacks, disheartening defeats, and disconcerting uncertainties. Yet, ironically, it is during these most despairing times that the critically ill are most in need of hope. As Groopman (2004) and others (Cousins, 1989; Post-White, 2003) suggest, hope is central to healing, helping the critically ill to live more liveable lives, if not more prolonged ones. Without hope, healing is impossible (Cousins, 1989; Groopman, 2004; Post-White, 2003), and as many a critical care nurse will attest, the critically ill simply "*give up*" and "*go downhill.*"

Accordingly, it stands to reason that, by successfully engendering hope, critical care nurses can positively influence healing in their critically ill patients and help them to prevail in the face of critical illness and its realities. Yet one wonders how critical care nurses engender hope in their critically ill patients. What does this engendering of hope entail? And experientially, in what ways does it enable critically ill patients to heal and to prevail? Before continuing to ponder these questions, however, it is perhaps prudent to digress momentarily to "briefly" explore the nature of hope. What is this thing called hope? How is it defined? Described? Characterized?

Various definitions of hope can be gleaned from the works of philosophers, theologians, behavioral scientists, and more contemporarily, from those in clinical fields (e.g., physicians and nurses). Despite their differences, these definitions commonly refer to hope within the context of potentially hopeless situations such as captivity, suffering, or other similar "prototypical experiences" (Farran, Herth, & Popovich, 1995, p. 7) such as illness and disability. Likewise, they tend to view hope either as an inner force or a feeling that is characterized by a fairly certain expectation of securing a future good or of being able to transcend the difficult circumstances of the present: A few of these definitions are offered herein.

For example, Marcel (1951) regards hope as "an active reaction against a state of captivity," a state in which he viewed "sickness" or "tragedy" as "forms" thereof (p. 160). Using himself as a reference point, he later states that "to hope is to carry within me the private assurance that however black things may seem, my intolerable situation cannot be final; there must be some way out" (p. 160). Similarly, Lynch (1965) contends that "hope is . . . a sense of the possible, that what we really need is possible, though difficult" (p. 32). Elsewhere he, like Marcel (1951), speaks of hope as having a sense that "there is a way out" (p. 35). Groopman (2004) defines hope as "the elevating feeling we experience when we see—in the mind's eye—a path to a better future," while adding that "hope acknowledges the significant obstacles and deep pitfalls along the path" and that "true hope has no room for delusion" (p. xiv). And finally, Dufault and Martocchio (1985) define hope as "a multidimensional dynamic life force characterized by a confident yet uncertain expectation of achieving a future good which, to the hoping person, is realistically possible and personally significant" (p. 380).

Further to their definition of hope, Dufault and Martocchio (1985) claim that hope can be conceptualized as being composed of two related, yet distinct, spheres: namely, the spheres of generalized hope and particularized hope. "Generalized hope is a sense of some future beneficial but indeterminate developments. It is broad in scope and not linked to any particular concrete or abstract object of hope" (i.e., "a valued outcome, good, or state of being"; p. 380). One does not hope for anything in particular; one just hopes. On the other hand, "particularized hope is concerned with . . . a hope object," whether it be "concrete or abstract, explicitly stated or implied" (p. 380). For example, one may hope to achieve symptom relief, to receive a transplant, to walk again, to regain independence, to return to work, or to accomplish something specific before dying.

Now, back to the task at hand, the task of responding to the questions regarding engendering hope that I posed earlier. I hope that having waited until now has been constructive in the sense of establishing some foundation from which to better understand the nature and significance of engendering hope in the critically ill as it is illuminated in the responses that follow.

One of the many ways in which nurses engender hope in the critically ill is by providing them with opportunities to experience success with immediate goals, a victory that relies on critical care nurses' good sense of timing and keen ability to set realistic and attainable goals. The anecdote about Ernie is a case in point. To Ernie, the taste of success inherent in being able to stand again and to briefly tolerate a plugging trial outside after a lengthy period of immobility and confinement was to him a sure sign of progress and, in turn, a hopeful sign. Being able to envision walking on his own again gave Ernie a sense of hope, a sense of hope that enabled him to muster the energy and enthusiasm to comply with his exercise regime, the very activity that, for him, was "critical to moving forward" (Post-White, 2003, p. 10), literally and figuratively.

Similarly, hope is engendered in critically ill patients when nurses make a point of pointing out evidence of progress that may be less evident to patients. Whether it be in reference to a lung that is clearing, a swelling that is resolving, a wound that is healing, a drainage that is diminishing, or a vital sign that is stabilizing, some indication that "*they are getting better*" is often sufficient to bring about a sense of hope, and with it the strength and perseverance to continue the battle. Likewise, allowing patients to assert themselves by offering them choice, involving them in their care, and eliciting their participation in decision making, all indirect or subtle ways of communicating improvement, can also imbue them with hope and leave them with the encouraging feeling that they are now back "on the winning side."

Nurses also engender hope in the critically ill by enacting various gestures aimed at the future, particularly those that reflect what is most meaningful in their patients' lives. The anecdote about Doug is a good exemplar. Recall that Doug was the young man in his 20s, married, with two young children, who was instantly struck with quadriplegia following an automobile accident. As his children were preparing to "*return to their home up north*" and "*weren't going to be seeing him for a while,*" they "*came into the unit [one by one] to say goodbye to him.*" Noting that his little son "*was truly upset that he had to leave his dad*" and that Doug himself "*was quite emotional*" at the time, Doug's nurse pulled the curtains and lifted his son onto the bed while telling him "*that it was okay to hug [his] dad and to give him a kiss before [he left].*"

And as he "*leaned over to give [his] dad a kiss,*" she placed Doug's arms around his son in a hug-like fashion, "*stepped outside the curtain, and just let them be.*"

After his family had left, his nurse went back in and talked to Doug for a while. They "*cried a little while together,*" and then she said, "*Okay, now you need to work to get home to them, and I'm going to help you get there. Are you ready?*" He replied, "*Yes.*" As she reflected on the incident, she commented:

> *Even though he knew he wouldn't walk again, I think that incident gave him something to look forward to in a very real way. He just couldn't lay there and give up on life. . . . I knew how much it would mean for them both, for the dad to be able to hug his son. So that's what I did, and it worked!*

As Doug embraced his son, he, himself, was embraced by hope. His nurse's gesture provided him with the reminder that, despite the reality that he would not walk again, there was still something very important, worthwhile, and meaningful to aim for, to work toward, and "*to look forward to*"*;* for example, to return home, to be "Dad," and to meaningfully participate in family activities again, albeit in new and different ways, all of which would help to make his life liveable again. Having been touched with hope in this manner gave him the fortitude he needed to embark on the long and arduous journey toward recovery and the resilience to endure it (Groopman, 2004). As the old saying goes, "Where there is a will, there is a way." Moreover, "Where there is hope, there is the courage to press on" (Olson, 1993, p. 31).

In many respects this anecdote reflects what Dufault and Martocchio (1985) consider among the merits of particularized hope. They write:

> Particularized hope clarifies, priorizes, and affirms what a hoping person perceives is most important in life. It preserves and restores the meaning in life. Particular hopes encourage investment in and commitment to something specific

> that extends beyond the present moment and provides an object toward which a hoping person's own energies and those of others can be directed. Hope in this sphere provides an incentive for constructive coping with obstacles and for devising alternative means to realize the object of hope. (p. 381)

The anecdote about Colin, the 50-year-old male who had been burned in a gas explosion, provides another example of how nurses engender hope by means of gestures aimed at the future. However, in this anecdote the actual gesture is different in nature. And thus, as an illustration of other important and viable means for engendering hope in the critically ill, either alone or, preferably, in conjunction with other means, this anecdote warrants mention.

While critically ill patients facing some degree of disfigurement or disability know immediately that their bodies have been dramatically and permanently altered, they are often unable "to grasp all the consequences for the long run" (Bergsma & Thomasma, 1982, p. 153). Nor can they easily project living into the future with their now changed bodies (Bergsma & Thomasma, 1982). Consequently, they initially live with a certain degree of uncertainty and, no doubt, a great deal of doubt—the makings for hopelessness. However, as the anecdote about Colin reveals, critical care nurses engender hope by sharing with patients what they know about the successful experiences of similar patients who came before them and by marshalling other human resources who have specialized knowledge to share, "survivors" being among them.

Recall that "*because of his burns [Colin] wasn't sure if he should follow through with*" his proposal of marriage to his girlfriend. While his nurse helped by acting as a "*sounding board*" and sharing what she knew about other patients' experiences, it was the opportunity that she provided for him to talk to a burn survivor that helped the most. As she explained, "*He discovered that he was not the only one who'd been through this—others had survived, and life goes on.*"

Survivors bring with them a realistic view of the future in a way that inspires hope. And as we now know, "hope makes life go on" (Dufault & Martocchio, 1985, p. 386). By affording Colin the chance to see and hear, firsthand, how everyday living is possible, this burn survivor gave him a target to shoot for. And now able to see his own future begin to fill with "liveable" possibilities, he subsequently rallied the courage to follow through with his plan to "*pop the question*" on Christmas Day. His girlfriend happily accepted, and they were married a few months later—we hope, happily ever after!

However, while "*life goes on*" for many critically ill patients, we know that, in reality, it does not go on for all. For any number of reasons, death in the critical care unit is inevitable for some and imminent for others. Thus it begs the question, How do nurses engender hope in those critically ill patients for whom there is no hope of cure? For whom there is no chance of surviving the battle?

Olson (1993) reminds us that for those critically ill patients who are dying, hope for a cure (or survival) becomes hope for "the presence of care" (p. 150), care that makes dying more liveable and, to the extent possible, care that enables them to "live" as they die. Accordingly, there are a number of ways in which critical care nurses engender hope in their critically ill patients as they, presumably knowingly, approach life's last milestone. And while there may be some variation on the basis of each patient's unique situation, many of the ways in which nurses engender hope in dying patients commonly applies to them all (i.e., dying patients) and in many respects, as will become evident, to all critically ill patients. Among them are maintaining presence, respecting dignity, permitting liberal family visitation, encouraging family involvement, palliating bodily discomforts, limiting or removing unnecessary de-humanizing technology, creating a more tranquil space, upholding religious practices, honoring last wishes, facilitating the completion of final business, and providing as much continuity with the patient's life as possible (Benner et al., 1999)—all of which can help endow the patient with the courage to face death and increase the likelihood of the patient having "*a good death.*"

CHAPTER 7

UNCOVERING ARTFUL CRITICAL CARE NURSING PRACTICE

> In the discovery of meaning, one gains wisdom (Burkhardt & Nagai-Jacobson, 2002).

This interpretive inquiry reveals the meaning in critical care nurses' lived experiences of making a difference in critical care nursing practice with a view to subsequently deepening an understanding of the art of nursing and pursuing nursing excellence. In particular, it "shows" how critical care nurses make a difference and what difference they make to patients who experience critical illness in a manner that more fully captures the reality, complexity, diversity, and subtlety embodied in artful nursing practice as it is enacted in the critical care setting.

The onset of critical illness abruptly changes the lives of those who have fallen victim, ransacking their bodies and shattering their worlds. Yet, in a state of limitless vulnerability, these victims, the critically ill, engage in a courageous battle— a battle against death, a battle against the ravages of disease or injury that threatens their lives. In fighting this battle, they are necessarily held captive within the high-tech battleground of the critical care unit; and, ironically, as the targets of attack by the joint forces who fight on their behalf, the wounds and insults they sustain during the course of the battle add to their victimized state.

Yet there is a notable allied force who make a difference in the lives of the critically ill as they rage their battle. They are the critical care nurses—the ones who take up the battle in the trenches, on the front lines, in response to the call of the vulnerable who need their care.

Given the inhumane nature of the battleground of the critical care unit and the de-humanizing nature of certain events associated with critical illness and critical illness care, critical care nurses make a difference by humanizing their critically ill patients' experiences of critical illness and critical illness care. By acknowledging human-ness, revealing human-ness, guarding against indignity, and combating the technological imperative, critical care nurses make this inhumane battleground more humane and counteract the de-humanization associated with life-threatening disease or injury and being held captive for diagnosis and treatment in the critical care unit.

Given that the experience of critical illness brings its share of burdens for the critically ill to bear, including the trials and tribulations associated with diagnosis and treatment in the critical care unit, critical care nurses make a difference by making the unbearable (or potentially unbearable) aspects of critical illness and its associated care more bearable. By tempering fear, conquering bodily dis-comfort, and assuaging alienation, critical care nurses help critically ill patients to bear, to endure, to "*get through*" the more "burdensome" aspects of the critical illness experience.

Given that the presence of life-threatening disease, injury, or complications, either from the underlying disease or injury itself or, ironically, from its diagnosis and treatment, places the lives of the critically ill in jeopardy, critical care nurses make a difference by sustaining the lives of many who are, or may be, at risk of dying because of unstable, perilous, critical, or life-threatening situations. By attending vigilantly, apprehending astutely, and acting skillfully, critical care nurses attain or maintain stable physiological functioning, prevent undesirable or destabilizing change, or rescue the critically ill from the grip of death in the event of physiological crisis.

Given the unliveableness of life-disrupting critical illness and its associated care, critical care nurses make a difference by making the unliveable as liveable as possible. By fostering normalcy and engendering hope, critical care nurses help patients to recover liveable relations with their bodies and their worlds such that their normal, self-forgetful state of the body and their normal engagement in the world are restored again as best as possible.

From the outset, the intent of this inquiry was not to develop a theory that is complete, but rather to pose a question that lives on, seeking never to be complete, just more completely understood. To that end, the intended aim of this inquiry has been accomplished. However, as the above statement intimates, in the grand scheme of things this inquiry actually represents "a work in progress," and thus in the truest sense it remains unfinished. Indeed, as Arendt (as cited in Cameron, 1998) reminds us, "Understanding is unending and therefore cannot produce final results" (p. 20). Thus, this interpretation is not a conclusion in the sense of completion, but rather one that constitutes an open ending; that is, one that acknowledges that there is much more to write, much more upon which to reflect, and much more about which to wonder.

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.
(Eliot, 1943, p. 39)

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APPENDIX A

VERBAL EXPLANATION OF THE INQUIRY TO POTENTIAL PARTICIPANTS

Appendix A: Verbal Explanation of the Inquiry to Potential Participants

Title of Project: "Making a Difference" in Critical Care Nursing Practice: An Interpretive Inquiry

Investigator: Patricia Hawley, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone (780) 433-0996

Supervisor: Dr. Louise Jensen, Professor
Faculty of Nursing, University of Alberta
Phone (780) 492-6795

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Hello, my name is Patricia Hawley. I am a registered nurse who has worked in critical care and I continue to have a special interest in this area of nursing practice. I am currently a doctoral student in the Faculty of Nursing at the University of Alberta.

As part of my doctoral program, I am conducting a study entitled, "Making a Difference" in Critical Care Nursing Practice. The purpose of the study is to explore the meaning of "making a difference" from critical care nurses' experiences. It may also help to deepen our understanding of how nursing "makes a difference" to the well-being of critically ill patients during this stressful time.

I am here to ask you to give some consideration to being a participant in my study. Although there will be no direct benefits for you, I believe that your sharing of these experiences will help to uncover the important and significant contribution that critical care nurses make to the well-being of patients. Your participation is strictly voluntary and unless you tell someone that you are involved in this study, no one but me will know. If you are willing to participate in the study I will need your written consent.

Title of Project: “Making a Difference” in Critical Care Nursing Practice: An Interpretive Inquiry

Investigator: Patricia Hawley, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone (780) 433-0996

Supervisor: Dr. Louise Jensen, Professor
Faculty of Nursing, University of Alberta
Phone (780) 492-6795

****

In helping you decide, let me give you some specific details about what will be involved. Participation in the study will involve approximately four informal conversations over a period of six to eight months. Each conversation should not last any longer than an hour, but if you want to talk longer that’s okay. In our first conversation you will be asked to tell me about an experience(s) in which you believed you “made a difference” in your practice. In the conversations that follow we will discuss the analysis as it unfolds. Prior to our final conversation you will read the final results which will be in the form of a text and similar to reading a story about the experience of “making a difference” in critical care nursing practice.

Title of Project: "Making a Difference" in Critical Care Nursing Practice: An Interpretive Inquiry

Investigator: Patricia Hawley, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone (780) 433-0996

Supervisor: Dr. Louise Jensen, Professor
Faculty of Nursing, University of Alberta
Phone (780) 492-6795

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Each conversation will take place at a time that is convenient for us both and in a place that is most comfortable for you (e.g., my office or your home). The conversations will be tape-recorded. Your name will not be tape-recorded, but your conversations will be given a code name. I will ask you to fill out a form that asks for some personal information (e.g., age, sex, marital status, years of critical care nursing experience, total years of nursing experience, the specific critical care unit employed in, level of nursing education obtained, and employment status) for the purpose of later describing my study participants. I will also need to obtain at least one contact number from you for arranging follow-up conversations. All information will be held confidential except when professional codes of ethics, legislation, or both requires reporting.

Title of Project: "Making a Difference" in Critical Care Nursing Practice: An Interpretive Inquiry

Investigator: Patricia Hawley, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone (780) 433-0996

Supervisor: Dr. Louise Jensen, Professor
Faculty of Nursing, University of Alberta
Phone (780) 492-6795

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There is a possibility that someone other than me will transcribe the conversations, however, this person will not be given any real names. My supervisory committee will also have access to the transcripts for the purpose of helping me with my analysis and writing. As I mentioned, only code names will appear on the transcripts. The tape recordings will be separated from any identifying information. All identifying information, consent forms, field notes, tapes, and transcripts will be securely kept by me in a locked cabinet. If the information of this study is further analyzed in future years, ethical clearance will be obtained prior to its use. The data will be securely kept by me for a period of seven years and then destroyed.

You are free to withdraw from the study at any time. You just need to inform me that you no longer want to participate. No reason needs to be given. No one but me will know of your decision and there will be no adverse consequences. If you withdraw from the study, any information that you have given me will be destroyed and not be used in the study.

Title of Project: "Making a Difference" in Critical Care Nursing Practice: An Interpretive Inquiry

Investigator: Patricia Hawley, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone (780) 433-0996

Supervisor: Dr. Louise Jensen, Professor
Faculty of Nursing, University of Alberta
Phone (780) 492-6795

****

As participation in the study will involve your recalling, and perhaps reliving, meaningful intimate moments from your nursing practice, there is a possibility that you may become emotional as you share these moments. In the event that issues beyond the scope of the study arise, we can discuss available resources that may offer more appropriate assistance to you.

It is most likely that excerpts or quotes from the conversations will be included in the final text for the purpose of providing examples or to enrich the text, but only code names will be associated with this information. The findings of this study may be published, presented at conferences, or both, but again, only code names will be used. If you would like to have your own copy of the final report, just indicate this on the consent form.

Do you have any questions or concerns that you would like me to address right now? Please feel free to contact me at any time should questions or concerns arise. If you are interested in participating in the study, please contact me at this number (433-0996) and we can talk about it in more detail. Thank you for your time.

Title of Project: "Making a Difference" in Critical Care Nursing Practice: An Interpretive Inquiry

Investigator: Patricia Hawley, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone (780) 433-0996

Supervisor: Dr. Louise Jensen, Professor
Faculty of Nursing, University of Alberta
Phone (780) 492-6795

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If you have any concerns about any aspect of this study, you may contact the Patient Concerns Office of the Capital Health Authority at 407-1040. This office has no affiliation with the study investigator.

APPENDIX B

RECRUITMENT NOTICE

Appendix B: Recruitment Notice

Title of Project: "Making a Difference" in Critical Care Nursing Practice: An Interpretive Inquiry

Investigator: Patricia Hawley, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone (780) 433-0996

Supervisor: Dr. Louise Jensen, Professor
Faculty of Nursing, University of Alberta
Phone (780) 492-6795

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WOULD YOU LIKE TO TALK ABOUT EXPERIENCES IN YOUR CRITICAL CARE NURSING PRACTICE WHERE YOU "MADE A DIFFERENCE"?
IF SO, MAYBE YOU WOULD LIKE TO VOLUNTEER TO BE IN MY RESEARCH STUDY!

I am a nurse who has worked in critical care and I continue to have a special interest in this area of nursing practice. As part of my doctoral program, I am conducting a study to explore the meaning of the experience of "making a difference" in critical care nursing practice.

The purpose of this study is to learn more about nursing practice as well as uncover the important and significant contribution that critical care nurses make to the well-being of patients.

Critical care nurses who agree to be in this study will be asked to talk about those experiences in which they believed they "made a difference" in their practice. It will be like an informal conversation.

Participation in the study will involve approximately four informal conversations over a period of six to eight months. Each conversation should not last longer than an hour, but if nurses want to talk longer, that's okay. The conversations will take place at a time that is convenient for both the researcher and the nurse and at a place that is most comfortable for the nurse participant (for example, at my office, at the nurse participant's home).

If you would like to hear more about the study before you decide if you would like to be involved, please call me at 433-0996.

APPENDIX C

CONSENT TO PARTICIPATE

Appendix C: Consent to Participate

Part 1 (to be completed by the Principal Investigator):
Title of Project: "Making a Difference" in Critical Care Nursing Practice: An Interpretive Inquiry
Investigator: Patricia Hawley, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone (780) 433-0996
Supervisor: Dr. Louise Jensen, Professor
Faculty of Nursing, University of Alberta
Phone (780) 492-6795

Part 2 (to be completed by the research subject):

Do you understand that you have been asked to be in a research study? Yes No

Have you read and received a copy of the attached Information Sheet? Yes No

Do you understand the benefits and risks involved in taking part in this research study? Yes No

Have you had an opportunity to ask questions and discuss this study? Yes No

Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your employment. No one but the researcher will know your decision. Yes No

Has the issue of confidentiality been explained to you? Do you understand who will have access to your taped/transcribed conversations? Yes No

Do you understand that your name will not be revealed? Yes No

Do you understand what your involvement in the study entails? Yes No

This study was explained to me by: Patricia Hawley
I agree to take part in this study.

Signature of Research Participant Date Witness

Printed Name Printed Name
I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT.
IF YOU WISH TO RECEIVE A SUMMARY OF THE STUDY WHEN IT IS FINISHED, PLEASE COMPLETE THE FOLLOWING:

NAME:
ADDRESS:

APPENDIX D

BIOGRAPHICAL DATA

Appendix D: Biographical Data

Code Name __________________

Age _____ years

Sex
_____ Female
_____ Male

Marital Status
_____ Married
_____ Divorced
_____ Widowed
_____ Separated
_____ Single
_____ Other (Please specify)
____

Level of Nursing Education Obtained
_____ Diploma
_____ Baccalaureate Degree
_____ Masters Degree
_____ Other (Please specify)
____

Current Critical Care Setting
_____ NSICU
_____ GSICU
_____ CVICU
_____ CCU
_____ Other (Please specify)
____

Years of Critical Care Nursing Experience
_____ < 1 year
_____ 1-5 years
_____ 6-10 years
_____ 11-15 years
_____ 16-20 years
_____ 21-25 years
_____ > 25 years

Years of Total Nursing Experience
_____ < 1 year
_____ 1-5 years
_____ 6-10 years
_____ 11-15 years
_____ 16-20 years
_____ 21-25 years
_____ > 25 years

Employment Status
_____ Full-time
_____ Part-time
_____ Casual
_____ Float

APPENDIX E

DESCRIPTION OF THE SAMPLE

Appendix E: Description of the Sample

Sixteen critical care nurses, all women, from several adult critical care settings (e.g., NSICU [n = 2], GSICU [n = 10], CCU [n = 2], CVICU [n = 1], Burn Unit [n = 1]) participated. These nurses (n = 15) ranged in age from 24 to 54 years, with a mean age of 41.06 years. The majority of the participants were between the ages of 36 and 50. Those between the ages of 46 and 50 represented the largest group. All participants were Caucasian. Six were married, four were divorced, four were single, and two were in long-term committed relationships. Twelve were educated at the diploma level, and four were Baccalaureate prepared. Thirteen were employed full-time, one part-time, and one casually. Their years of critical care nursing experience ranged from less than one year to 25 years or more. More than 50% had 11 or more years of experience in critical care nursing. Their years of total nursing experience followed a similar trajectory, with 75% having more than 11 years of total nursing experience. The majority of the participants pursued critical care nursing within five years of graduating from their entry-level program.